Overlake EyeCare, PS

Patient Registration Form

PATIENT

SALUTE
[ ] Miss [ ] Mr
[ ] Mrs [ ] Ms
[ ] Dr

FIRST NAME | LAST NAME | MIDDLE | SUFFIX [ ] Sr [ ] Jr [ ] _____ | NICKNAME

ADDRESS 1 | ADDRESS 2 | CITY | STATE/PROV | POSTAL CODE

BIRTH DATE (mm/dd/yyyy) | SOCIAL SEC # | GUARANTOR [ ] Self [ ] Spouse [ ] Parent [ ] Partner [ ] _____ | GENDER [ ] Male [ ] Female

PREFERRED LANGUAGE
[ ] English
[ ] _____

RACE
[ ] American Indian/Alaska Native [ ] Asian
[ ] Black/African American [ ] Native Hawaiian/Pacific Islander
[ ] Other _____ [ ] White

ETHNICITY
[ ] Hispanic/Latino
[ ] Non Hispanic/Latino

HOME PHONE ( ) | WORK PHONE / EXT ( ) | CELL PHONE ( ) | PAGER ( ) | EMAIL ADDRESS

GUARANTOR

SKIP THIS SECTION IF GUARANTOR IS SELF

LAST NAME | FIRST NAME | MIDDLE | BIRTH DATE (mm/dd/yyyy) | SOCIAL SECURITY #

ADDRESS | CITY | STATE/PROV | POSTAL CODE | HOME PHONE ( ) | WORK PHONE / EXT ( )

REFERRAL

HOW DID YOU SELECT OUR OFFICE?

[ ] PHYSICIAN REFERRAL * [ ] FAMILY/FRIEND * [ ] INSURANCE CO. [ ] INTERNET
[ ] NEWSPAPER [ ] RADIO [ ] T.V. [ ] YELLOW PAGES

* NAME OF THE PERSON WHO REFERRED YOU

PAYMENT

HOW WILL YOU BE PAYING?

[ ] CASH [ ] CHECK ($25 charge for all returned checks)

[ ] INSURANCE (Please show your cards to receptionist)

[ ] AMEX [ ] DISCOVER [ ] MASTERCARD [ ] VISA

PHYSICIANS

PRIMARY CARE PHYSICIAN | SPECIALTY (eg family med) | ADDRESS / LOCATION OF PRIMARY CARE PHYSICIAN

PHYSICIAN #2 | SPECIALTY (eg cardiologist) | ADDRESS / LOCATION OF PHYSICIAN #2

PHYSICIAN #3 | SPECIALTY (eg cardiologist) | ADDRESS / LOCATION OF PHYSICIAN #3

SIGNATURE

OFFICE FINANCIAL POLICY, PRIVACY PRACTICES ACKNOWLEGEMENT AND INSURANCE LIFETIME AUTHORIZATION

When we bill your insurance company, you are still directly responsible for any fees that they do not pay including co-payments, deductibles and non-covered services. If you are covered by managed care insurance that requires prior authorization for our services you are responsible for obtaining the authorization before we render services. We will apply a $5.00 statement charge each month to all accounts that are over 60 days past due. You acknowledge that you have reviewed or have been given a copy our office's notice of privacy practices as required by HIPAA. You also request payment of government or private insurance benefits to Overlake EyeCare, PS when we accept assignment for services and materials provide

[ ] Self [ ] Spouse
[ ] Parent [ ] Child [ ] Other

X_____ | _____ | _____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE | DATE (mm/dd/yyyy) | RELATIONSHIP TO INSURED