

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT DEMOGRAPHICS

DATE _____ SOC. SEC. NO.: _____
FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
SEX _____ D.O.B. ____/____/____ MARITAL STATUS _____ RACE _____ LANGUAGE _____
E-MAIL _____ PHONE () _____ WORK () _____
FEA PHYSICIAN _____ MOBILE/CELL () _____
REFERRAL SOURCE _____ REFERRING PROVIDER _____
EMPLOYMENT STATUS _____ EMPLOYER _____
EMPLOYER'S ADDRESS: _____

INSURANCE

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP # _____ PHONE () _____

SECONDARY INSURANCE INFORMATION

Commercial Medicaid Medicare Worker's Compensation Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP # _____ PHONE () _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE () _____
DATE OF INJURY _____
SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE () _____

EMERGENCY CONTACT

PATIENT'S RELATIONSHIP TO CONTACT: _____
SEX _____ LANGUAGE _____
FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____
HOME PHONE _____ WORK PHONE _____
 CONTACT IS PARENT / GUARDIAN

PARENT / GUARDIAN / SPOUSE

PATIENT'S RELATIONSHIP TO GUARDIAN: _____
SOCIAL SECURITY NUMBER _____ SEX _____
FIRST NAME _____ LANGUAGE _____
MIDDLE NAME _____ HOME PHONE _____
LAST NAME _____ WORK PHONE _____

CORRESPONDENCE WILL BE MAILED TO PARENT/GUARDIAN AT THE PATIENT'S ADDRESS.

MEDICARE/MEDIGAP

Lifetime Authorization MEDICARE Certification For Payment.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request that this authorization also apply to all other insurance.

I request that payment of authorized MEDIGAP benefits be made on my behalf to Florida Eye Associates for any services furnished me by Florida Eye Associates. I authorize any holder of medical information about me to release any information needed to determine these benefits to Florida Eye Associates

SIGNATURE: _____ Date: _____

FOR TREATMENT / PAYMENT ALL INSURANCES

FOR ALL INSURANCE COMPANIES

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process this claim and request payments of benefits to Florida Eye Associates who accepts assignment. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

I authorize Florida Eye Associates to use medical information about me to provide me with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have authorized such disclosure. These entities include third-party physicians, hospitals, nursing homes, pharmacies, or clinical labs with whom the office consults or makes referrals. Your signature below authorizes such disclosure.

I authorize Florida Eye Associates to use and disclose medical billing information about me so that the treatment and services I receive at your office may be billed to and payment may be collected from me, an insurance company, or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

SIGNATURE: _____ Date: _____