PATIENT REGISTRATION FORM

DATE ____________________

DOCTOR ____________________

Primary Care Physician: ______________________________

Referred by: ______________________________

ALLERGIES: ______________

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CASH PAY ☐ WC ☐ MEDICARE ☐ MEDI-CAL ☐ PRIVATE INS. ☐ SCMG GRP. ________				
Patients Name: Last First Middle			Sex M F	Social Security #
Street Address			Birth date	Age
City State Zip			Phone # with area code Home ( ) Cell ( )	
Relationship to insured --- Circle one Self Spouse Child Other	Insurance ID #		Marital Status -- Circle one S M D W	
Employer	Occupation		Work Phone with area code ( )	
Responsible Party (name of insured)		Birth date	Social Security #	
Street Address City State Zip			Phone with area code Home ( ) Cell ( )	
Emergency Contact Person Currently Not Living With You Name			Phone with area code Home ( ) Cell ( )	

PATIENT WAIVER

The doctor accepts you as his/her patient with the understanding that you are ultimately responsible for the cost of all professional services rendered by him/her, to you or your dependents.

It must be understood that depending upon your insurance contract benefits you may be responsible for portions of the charges not paid by insurance. If insurance fails to pay when billed, you are expected to make prompt, satisfactory arrangements to settle your account.

PRIVATE INSURANCE ASSIGNMENT

I authorize payment of Medical Benefits to Eye Physicians Medical Group, Inc., for services rendered to me and also authorize the release of any medical information necessary to process this claim.

Signed by: ____ Date: ______________

CASH PAY PATIENTS

The person whose signature appears on this form will be considered financially responsible for the patient.

Signed by: ____ Date: ______________

MEDICARE ASSIGNMENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eye Physicians Medical Group, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or benefits payable for related services.

Signed by: ____ Date: ______________

(see other side)