MICROSURGICAL EYE CONSULTANTS

REGISTRATION FORM

PERSONAL INFORMATION

NAME_____ EMAIL_____

☐ MALE ☐ FEMALE CELL PHONE ( ) _____ HOME PHONE ( ) _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE _____

HOME ADDRESS/STREET _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

OCCUPATION _____ SOCIAL SECURITY NUMBER _____ - _____ - _____

EMPLOYER _____ WORK PHONE ( ) _____

EMPLOYER ADDRESS/STREET _____CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____SPOUSE'S OCCUPATION _____SPOUSE'S WORK # ( ) _____

IN CASE OF EMERGENCY, PLEASE NOTIFY _____ CONTACT # ( ) _____

PRIMARY CARE PHYSICIAN _____REFERRED BY _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER'S NAME _____

POLICY HOLDER'S SS #_____ - ____ - _____ D.O.B. _____

INSURANCE ADDRESS _____

POLICY # _____ GROUP # _____

COMPANY NAME _____ COMPANY ADDRESS _____

SECONDARY INSURANCE _____ POLICY HOLDER'S NAME _____

POLICY HOLDER'S SS #_____ - ____ - _____ D.O.B._____

INSURANCE ADDRESS _____

POLICY # _____ GROUP # _____

COMPANY NAME _____ COMPANY ADDRESS _____

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS TO PHYSICIAN: I hereby authorize assignment of payments directly to Microsurgical Eye Consultants for the surgical and/or medical benefits, if any, otherwise payable to me for the services described above. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize Microsurgical Eye Consultants to release any information relative to medical care received by me.

SIGNED _____ DATE _____
(Insured or Authorized Person)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I understand I may obtain a copy of this practice's Notice of Privacy Practices, which provides me with a complete description of the uses and disclosures of certain health information. I understand that I am entitled to receive a copy of this document.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

SIGNATURE _____ DATE _____
(Name of Patient or Guardian)