

# ATLANTIC EYE PATIENT REGISTRATION FORM

Acct #: \_\_\_\_\_

## PATIENT INFORMATION

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ MI: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Marital Status(circle one): S / M / D / W Employment(circle one): Full / Part / Self / None / Retired / Military / Student

Employer/School Name: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we contact you by email? Yes / No

Primary Care Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## SPOUSE INFORMATION (RESPONSIBLE PARTY – if minor)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Relationship to Patient: Self / Spouse / Parent / Other \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Relationship to Patient: Self / Spouse / Parent / Other \_\_\_\_\_

How Did You Hear About Us?(circle one): Google / Yahoo / MSN / Safari / AOL / Sign / Billboard / Yellow Pages

Newspaper (what paper?) \_\_\_\_\_ / Radio (what station?) \_\_\_\_\_ / TV (what station?) \_\_\_\_\_

Friend/Relative or Doctor (who?) \_\_\_\_\_ / Other \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only: Special Notes \_\_\_\_\_

## FINANCIAL ASSIGNMENT AND AGREEMENT

1. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is **not** a substitute of payment or release of financial responsibility. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance and any other balance not paid by your insurance company.
2. In order to control billing costs, we request that all deductible, co-insurance or co-pay amounts for office visits be paid at the conclusion of each visit. Charges for self-pay & out-of-network insurances are expected to be paid in full at the conclusion of each visit. Patients that do not present proof of applicable insurance will be considered self pay until appropriate proof is presented. **We reserve the right to charge your account a statement fee for any balance that has to be collected after the date of your visit. All collection charges or attorney fees associated with past due accounts will be added to your balance.**
3. I request that the payment of authorized Medicare and/or insurance benefits be made on my behalf for any services provided to me. I authorize the release of all medical information about me to the Centers for Medicare & Medicaid Services (CMS) or any other insurance carrier I may have, in order to determine the benefits payable for services I have received or that I am considering.
4. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

## PAYMENT INFORMATION

Today's visit, co-pay, or cost share will be paid with (initial appropriate answer):

\_\_\_\_\_ Cash          \_\_\_\_\_ Check          \_\_\_\_\_ Credit/Debit Card (we accept Visa, MC, Amex & Disc)  
\_\_\_\_\_ Worker's Compensation (**prior** authorization is required)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*PLEASE NOTE: A \$25.00 FEE WILL BE CHARGED TO YOUR ACCOUNT IF YOU CANCEL OR RESCHEDULE AN APPOINTMENT LESS THAN 24 HOURS PRIOR TO YOUR APPOINTMENT TIME OR IF YOU DO NOT SHOW FOR YOUR APPOINTMENT.**