Patient Registration Form

For internal use only:
☐ _____ ☐ _____
☐ _____ ☐ _____

Legal Name: _____ ____ _____
First MI Last

Please Circle: Mr. / Mrs. / Ms. / Dr. Birth Date:_____ Social Security #_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Email Address:_____

Employer:_____Work Address:_____

Type of work you do:_____Hours of computer use per day: _____

Hobbies and Interests_____

Primary Care Physician (PCP) Name:_____ Phone:_____

Address:_____

How did you hear about our office?_____

If child is under 18 years of age, guarantor (person responsible for payment) is:

Name:_____ Phone:_____ Address:_____

ASSIGNMENT OF BENEFITS

I request that payment by my third party insurance be made directly to Linda Bennett, O.D., Melanie Macbeth, O.D., and Rebecca Maida, O.D. for any services rendered. I authorize that the holder of my medical information release to HCFA and other insurance entities information to determine the benefits payable for related services. I understand that I am responsible for non-covered services.

CONTACT LENS FEES

Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes.

OPTOMAP FEE

Insurance carriers do not cover wellness eye photography. However, we highly recommend it. You will be responsible for this fee if you elect to have your Optomap Retinal Exam viewed by your doctor.

ACKOWLEDGEMENT OF NEED FOR REFERRAL

I am aware that my insurance carrier may require that I obtain a referral from my primary care physician. I understand that I am liable for all fees if I do not obtain a referral in a timely manner.

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

Signature_____ Date_____