OFFICE PARK EYE CENTER

PATIENT REGISTRATION

Please Print – All Information Required -- Insurance cards must be presented at check-in

NAME: _____ BIRTHDATE: _____ SEX: M / F

ADDRESS: _____ Marital Status: S / M / W / D

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ EMAIL: _____

(Required for copy of records)

EMPLOYER:_____PHONE: _____Patient's SSN:_____

Please circle which phone number you prefer to receive appointment reminders.

Following items required by the federal government:

Primary Language: _____ Race: _____ Ethnicity: Hispanic / Non-Hispanic / Unknown

Decline to answer:

Complete if patient under 18 years or a student:

Father _____ DOB _____ Employer _____SSN:_____

Mother _____ DOB _____ Employer _____SSN:_____

Complete if married:

Spouse _____ DOB _____ Employer _____ SSN: _____

GUARDIAN PAPERS: _____ DURABLE POWER FOR HEALTH CARE:_____ ADVANCED DIRECTIVES: _____

(IF YES TO ABOVE QUESTIONS, PLEASE PROVIDE A COPY FOR YOUR MEDICAL RECORD)

EMERGENCY CONTACT: _____RELATION_____PHONE:_____

REFERRING PHYSICIAN: _____ PHONE:_____ SEND CORRESPONDENCE Y N

PRIMARY CARE PHYSICIAN: _____ PHONE: _____SEND CORRESPONDENCE Y N

ADDITIONAL PHYSICIAN: _____ PHONE: _____SEND CORRESPONDENCE Y N

PHARMACY: _____ PHONE: _____

AUTHORIZATION FOR TREATMENT: I hereby authorize the physicians of the Office Park Eye Center to render medical and surgical treatment for my condition(s) as determined to be medically necessary.

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Onslow Ophthalmology, dba Office Park Eye Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the release of all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION: In addition to the above authorized physicians, my condition and/or financial status may be discussed with _____ who is related to me as my _____.

Signed: _____ Date: _____

If a minor or guardian, state your relationship to patient: _____