PATIENT REGISTRATION

NAME: ______________________ SEX (Circle One): **MALE** **FEMALE**

DATE OF BIRTH: ____________ AGE: ________ SOCIAL SECURITY #: ______________

HOME PHONE: ______________ CELL PHONE: ______________

WORK PHONE: ______________ EMAIL: ______________

HOME ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP: ________

MARITAL STATUS (Circle One): **MARRIED** **WIDOWED** **DIVORCED** **SINGLE**

IS PATIENT A RESIDENT OF A SKILLED NURSING FACILITY? (CIRCLE ONE) **YES** **NO**

IS PATIENT PART OF A HOSPICE PROGRAM? (CIRCLE ONE) **YES** **NO**

EMERGENCY CONTACT INFORMATION:

NAME: ______________________

RELATION: ______________

PHONE: ______________

PHYSICIAN INFORMATION:

REFERRING DOCTOR: ______________ PHONE: ______________

FAMILY DOCTOR: ______________ PH: ________ FAX: ________

ADDRESS: ______________ CITY: ________ STATE: ____ ZIP: ____

INSURANCE INFORMATION – ONLY MEDICAL HEALTH PLANS WILL BE BILLED – NO VISION PLANS

PRIMARY HEALTH INSURANCE:

INSURANCE COMPANY: ______________________

POLICY HOLDER'S NAME: ______________ DATE OF BIRTH: ________

SECONDARY HEALTH INSURANCE:

INSURANCE COMPANY: ______________________

POLICY HOLDER'S NAME: ______________ DATE OF BIRTH: ________

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ ACCEPTANCE OF HIPPAA REGULATIONS

I hereby authorize Midwest Eye Professionals (MEP), and its agents, to release to and discuss with my insurance company, physician, and/or employer, for work related injuries, any information acquired by MEP in the course of my examination or treatment. I hereby authorize benefits to be paid directly to the provider. I understand that payment of charges is not contingent upon settlement from my insurance carrier and that I am responsible for any unpaid balance. Please note that any and all patient accounts that require any outside collection assistance will be charged an additional fee of $25.00 as well as any attorney or court costs. If an appointment is missed or canceled without 24 hour notice, there will be a $30 fee charged to your account. Our notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing consent. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reference to your prior consent.

PATIENT/LEGAL GUARDIAN SIGNATURE ______________________ DATE ________