THE MEDICAL EYE CENTER - PATIENT REGISTRATION

Name:	Marital Status: S M W D	Date of Birth:	Sex:

Address:

Home Telephone:	Other phone (i.e. Work, Cell):	Email address:	Primary Care Physician:

Employer Name:	Preferred Method of Communication: ☐ Mail ☐ Phone ☐ My E-Chart	
Emergency Contact: Name:	Telephone:	Relationship:
Ethnic Group:	Race:	

Who referred you, or how did you hear of our practice?

☐ **I authorize the results of my examination and diagnostic testing to be used for educational purposes. Any information used will be masked to protect my identity.**

☐ **My results may not be used for educational purposes.**

GUARANTOR INFORMATION (Parent/Guardian for patients under 18)

Guarantor Name:	Guarantor Date of Birth:
Address:	
Home Telephone:	Guarantor's Employer:
Power of Attorney (If Applicable):	

INSURANCE INFORMATION

Primary Insurance:	Insurance ID Number:	
Subscriber:	Group Number:	Relationship to Subscriber:
Subscriber Employer:	Subscriber Date Of Birth:	

Secondary Insurance:	Insurance ID Number:	
Subscriber:	Group Number:	Relationship To Subscriber:
Group Employer:	Subscriber Date Of Birth:	

TREATMENT OF A MINOR (if applicable)

I authorize the treatment of my child / dependent (circle one) at The Medical Eye Center.

SIGNATURE (PATIENT OR REPRESENTATIVE): _____ DATE: _____

INSURANCE AUTHORIZATION AND CONSENT

I request that payment of authorized insurance benefits may be made to The Medical Eye Center for service rendered I authorize any holder of medical information about me to release to my insurance carrier(s) and its agents any information needed to determine the benefits payable for related services. This agreement is valid for any services that The Medical Eye Center provides during my lifetime. I understand that there are some services provided by The Medical Eye Center that may not be covered by my insurance carrier(s). I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE (PATIENT OR REPRESENTATIVE): _____ DATE: _____