Arezo Amirikia M.D., P.C.

Patient Registration

PATIENT INFORMATION

Name _____ Age _____ Date _____
Date of Birth _____ SS# _____ Sex: M F
Phone: Home _____Work_____ Cell _____
Address _____
City _____ State _____ Zip Code _____
Referred by: _____Email_____
Primary Care Physician _____ Phone _____

PHARMACY INFORMATION

Please provide any information you may know about your pharmacy (local or mail order).
Name of Pharmacy _____
Cross Roads_____ City _____ State _____ Zip _____
Phone _____ Fax _____
Please Check: □ 30 day supply □ 90 day supply

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Home _____ Cell _____ Work _____
Address _____ City _____ State _____ Zip _____

PRIMARY MEDICAL INSURANCE

Please Check: □ Medicare □ BCBS □ Blue Care Network □ Priority Health
□ HAP □ PPOM/Cofinity □ United Health Care □ Military
□ Self Pay □ Other _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M F
Subscriber Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Employer Phone _____
Employer Address _____ City _____ State ____ Zip _____

SECONDARY MEDICAL INSURANCE

Please Check: □ Medicare □ BCBS □ Blue Care Network □ Priority Health
□ HAP □ PPOM/Cofinity □ United Health Care □ Military
□ Self Pay □ Other _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M F
Subscriber Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Employer Phone _____
Employer Address _____ City _____ State ____ Zip _____

(Please continue on back)

VISION INSURANCE

Please Check: □ BCBS Vision □ VSP □ Eyemed □ Optum Health Vision (Spectera)
□ NVA □ Heritage □ Delta Vision □ Superior Vision
□ MEBS □ MECA □ Other _____

□ I do not have any vision insurance. I understand that I will be financially responsible on the day of service for any vision services/products received. Please initial _____

Subscriber Name _____ Relationship to Patient _____
Subscriber SS# _____ Subscriber Birth Date _____ Sex: M F
Subscriber Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Employer Phone _____

WORKERS COMPENSATION (Please Complete if Applicable)

Date of Injury _____
Business Name _____ Business Phone _____
Business Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO DISCUSS MY MEDICAL RECORDS

Please list any person(s) you wish to permit access to your protected medical information.
I authorize _____,
relationship to me _____, to discuss my medical condition with Dr. Arezo Amirikia or Dr. Denise Duffy or their designee and to obtain any test results on my behalf.

AUTHORIZATION FOR TREATMENT AND BILLING

I hereby authorize Arezo Amirikia, M.D., P.C., and its physicians, to treat me (or my dependent child) and to release any medical information required by my insurance carrier. If Arezo Amirikia, M.D., P.C. and its physicians participate with my insurance carrier, I authorize and request my insurance carrier to pay directly to Arezo Amirikia, M.D., P.C. for medical, surgical, or vision services rendered, not to exceed the reasonable and customary charges. I understand that I am financially responsible for charges not covered, authorized or paid by my insurance. I understand that balances not paid by my insurance carrier after **90 days** may become my responsibility. Patient balances over 90 days will be assessed a monthly finance fee of **4%** if arrangements have not been made with the billing department. Accounts turned over to collections will be assessed a processing fee of **$25.00**.
I understand that I must give 24 hour notice when cancelling or rescheduling an appointment. Failure to do so will result in a **$50.00** fee.
All returned checks will be assessed a $25.00 fee.
A fee of **$25.00** will be assessed for any patient electing to obtain their PD (Pupillary Distance) measurement as this is not part of your eye exam.
I have received a copy of the Arezo Amirikia, M.D., P.C. Notice of Privacy Practices for Protected Health Information.

Print Name _____

Patient Signature _____

Date _____