LIOC LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

BELLMORE	GREAT NECK	HUNTINGTON	LITTLE NECK
2450 Merrick Road	560 Northern Boulevard	158 Main Street	54-44 Little Neck Pkwy #3
Bellmore, NY 11710	Great Neck, NY 11020	Huntington, NY 11743	Little Neck, NY 11362

PATIENT REGISTRATION

PATIENT NAME: _____ DATE: _____
Last First Middle

ADDRESS: _____
Street City State Zip Code

SS #: _____ DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE MARRIAGE STATUS:_____

HOME PHONE #: _____ BUSINESS PHONE #: _____CELL #_____

EMAIL: _____

RACE: ☐ Native American ☐ Asian ☐ African American ☐ Caucasian ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

OCCUPATION: _____ EMPLOYER'S NAME: _____

Pharmacy:_____

NATURE OF COMPLAINT: _____ **DATE OF ONSET**: _____

NAME, ADDRESS, TEL # OF PRIMARY PHYSICIAN: _____

_____

WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____ PHONE: _____Relationship:_____

MOTHER'S NAME: _____ FATHER'S NAME: _____

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

INSURANCE SECONDARY

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

IF AUTO RELATED: FILE # _____ WRITTEN REPORT FILED? _____

IF WORK RELATED: CARR. CASE # _____ WCB # _____

INSURANCE PAYMENT ORDER:

I authorize my insurance company to pay directly to George Tung, MD, all benefits due to me. This policy was in full force and effect at the time of treatment. I understand that I am financially responsible for all balances remaining after payment of possible insurance benefits and that, should it become necessary, any and all reasonable collection/attorney fees will be added to the patient's bill. I permit a copy of this authorization to be used in place of the original.

Legal Signature_____ Date_____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize George Tung, MD, to furnish information to my insurance carriers and to other physicians who may become involved in my care, concerning illness and treatments received by me. I permit a copy of this authorization to be used in place of the original.

Legal Signature_____ Date_____