ADULT REGISTRATION FORM

DATE:______________________

Patient's Name: ____ Date of Birth: ______________________
Last *First* *MI*

Gender: M F Marital Status: __________________________ Social Security #: _______________________

Home Address: ____
Number and Street *City* *State* *Zip*

Mailing Address: ____
Street *City* *St* *Zip*

Phone Numbers: ____
Home *Cell* *Work*

E-Mail address: __________________________________ Referred by: ______________________________________

ARE YOU IN A SKILLED NURSING FACILITY? Y N If Yes, NAME:____________________________________

Employer: ____Employer Ph #: _________________________

Emergency Contact: ____ Relationship: _______________________
Last *First*
Telephone No.: ____

Insurance Information:

Primary Insurance: ____ Effective Date: __________________

Policy Holder's Name: __________________________________ DOB: ____________ Relationship: ______________

Subscriber ID: _________________________ Group No.: ____________ Social Security #: _____________________

Secondary Insurance: ____ Effective Date: _________________

Policy Holder's Name: __________________________________ DOB: ____________ Relationship: ______________

Subscriber ID: _________________________ Group No.: ____________ Social Security #: _____________________

Vision Plan: ____ Effective Date: ______________________

Policy Holder's Name: __________________________________ DOB: ____________ Relationship: ______________

Subscriber ID: _________________________ Group No.: ____________ Social Security #: _____________________

OVER-→

I realize that I am responsible for payment for all medical services rendered to me and/or my dependents, regardless of the decision to reimburse or not reimburse made by my insurance carrier. I also understand that my insurance will be billed as a courtesy to me. It is my responsibility to know my coverage terms, including the need for prior authorization. I hereby assign benefits to which I am entitled for medical and/or surgical expenses relative to the services performed. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked in writing by me.

____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*

If I refuse to sign the above, I understand that my insurance will not be billed and I am prepared to pay, in full, all services rendered to me at the time of service.

I am aware of the privacy standards of Pacific Eye and my rights and responsibilities as a patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. All exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with Pacific Eye's policy. I am also aware that there are times when Pacific Eye will share my medical chart with other physicians who participate in my medical care. By marking the appropriate box below, I give permission for Pacific Eye to share my medical records with others in the medical field to assist in my over-all medical care.

☐ **I authorize** the practice to release any or all information concerning my medical care to other physicians, insurance carriers, and other medical institutions who collectively care in my healthcare.

☐ **I authorize** the practice to release any or all information concerning my medical care to the individual listed as my **emergency contact.**

☐ **I authorize** the practice to release any or all information concerning my medical care to the individual(s) **listed below:**

Name: ____ Relationship to Patient: _________________________

DOB: ______________________________ Phone : ________________________________

Name: ____ Relationship to Patient: _________________________

DOB: ______________________________ Phone : ________________________________

____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*

I understand that I may be charged for a **REFRACTION**. This is a specialized test that allows your doctor necessary information to properly diagnose visual acuity. At the time of the refraction, my physician may perform a routine refraction or I may need, based on my medical condition, a more complex refraction. This fee will range between $50-$90 dollars. My insurance carrier may deem refractions as a non-covered benefit. This means, I will be responsible for payment in full for refraction services provided. I also understand that refraction payment will be collected at the time of service.

____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*

The above information is true to the best of my knowledge.

____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*