TODAY'S DATE: _____

PATIENT REGISTRATION

(This form must be updated every 12 months per insurance regulations)

PATIENT INFORMATION:

Last	First	Male ☐ Female ☐	S.S. #
Street Address		Adult ☐ Child ☐	Home Phone #
City	State / Zip Code	Date of Birth	Cell Phone #
Were you referred to this office? If yes, please state full name of individual.			

PATIENT'S/GUARDIAN'S INFORMATION:

Father's/Guardian's Name

Last	First	Date of Birth	S.S. #
Street Address (if same as above – write same)		Home Phone #	Cell Phone #
City	State / Zip Code	E-Mail Address	
Employer	Occupation	Business Phone #	

Mother's/Guardian's Name

Last	First	Date of Birth	S.S. #
Street Address (if same as above – write same)		Home Phone #	Cell Phone #
City	State / Zip Code	E-Mail Address	
Employer	Occupation	Business Phone #	

WHO IS YOUR PRIMARY PHYSICIAN/PEDIATRICIAN:

Name of Physician/Pediatrician	Telephone #	
Street Address	Do you want a letter sent to your doctor?	
City	State	Zip Code

INSURANCE INFORMATION:

Name of PRIMARY Insurance		Name of SECODNARY Insurance	
I.D. #	Group #	I.D. #	Group #
Who is policy holder/responsible party?	Relation to Patient	Who is policy holder/responsible party?	Relation to Patient
Is a referral required:	Co-Pay Amount	Is a referral required:	Co-Pay Amount

I understand and agree that (regardless of my insurance status) I am responsible for all charges on this account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify that all information is true and correct to the best of my knowledge. I will notify PEDIATRIC EYECARE OF MONMOUTH of any changes in this insurance or any changes to above information. I authorize the release of any medical information necessary to process claims on my behalf. I permit a copy of this authorization/signature be used in place of the original on all my insurance submissions.

I request payment from my insurance to be made directly to PEDIATRIC EYECARE OF MONMOUTH (when they accept assignment). If the insurance check is mailed to me in error, I will send the check within one week or be charged the amount of the check plus interest.

Parent's/Guardian Signature	Relationship to Patient	Date