South Hills Eye Associates, Ltd -- Patient Registration Form

First Name: _____ **Middle:** _____ **Last Name:** _____

Birth Date: **Month:** _____ **Day:** _____ **Year:** _____ **Martial Status:**

- Single ☐
- Married ☐
- Widow ☐
- Divorsed ☐
- Separated ☐
- Unknown ☐
- Other ☐

Address: _____

_____

_____

City: _____ **State:** _____ **Zip Code:** _____

County: _____ **Country:** _____ **Social Secuirty#:** _____

Phone: **Home:** _____ **Cell:** _____ **Work:** _____

E-Mail Address: _____

Race: _____ **Language Spoken:** _____

Ethnicity:

- Hispanic or Latino ☐
- Not Hispanic or Latino ☐
- Patient Declined ☐
- Other ☐

Employment Status :

- Employed ☐
- Retired ☐
- Unemployed ☐
- Self Employed ☐
- Student ☐

Occupation: _____

Employer: _____

_____

Emergency Contacts: **Name:** _____

Relationship to Patient: _____

Phone: **Home:** _____ **Cell:** _____ **Work:** _____

Primary Care Doctor: _____

Pharmacy: **Name:** _____

Location: _____

Phone: _____

Insurance Information:

Name of Insurance on Card: _____ **Insured person:**

- Patient ☐
- Guarantor ☐
- Other ☐

Insured ID: _____

Policy Group Number: _____ **Co-Pay :** **Medical:** **Specialist:** _____

Fee and Payments:

Please remember that insurance is not a substitute for payment.

It is your responsibility to pay any deductible amount, co-insurance, non-covered service, or any other balance not paid for by your insurance company. I authorize the release of payment for medical benefits to my physician.

This signature on file is authorization for the release of information necessary to process my claim. I hereby authorize the doctors of South Hills Eye Associates to furnish information to insurance carrier.

I give permission to release medical records or information to other medical doctors.

Date:_____Signature Of Patient:_____

Date:_____If Patient is a Minor/Parent's Signature_____