

CORNEAL ASSOCIATES, PC

PATIENT REGISTRATION

Please assist us in obtaining complete information so that we may bill your insurance company. By law, we are required to bill Medicare directly if you have coverage. Additionally, we bill directly to all insurance companies with which we participate. If you have an insurance carrier with which we do not participate, we will be happy to assist you in filing the claim, but payment is expected at the time of service.

NAME _____ Mr. Mrs. Ms. Miss MD (circle one)
Last Name, First Name, Middle Initial

ADDRESS _____

CITY/STATE/ZIP CODE _____

HOME PHONE (____) _____

OCCUPATION (include retired or homemaker) _____

EMPLOYER NAME _____

WORK PHONE (____) _____ SOCIAL SECURITY NUMBER _____

BIRTH DATE _____ SEX: MALE FEMALE (please circle one)

EMERGENCY CONTACT : _____ PHONE (____) _____

RELATIONSHIP TO CONTACT: _____

STUDENT STATUS: FULL-TIME PART-TIME (If in school, please circle one)

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

PLEASE DESCRIBE YOURSELF: CAUCASIAN AFRICAN-AMERICAN HISPANIC ASIAN _____ (Other)

Please note that the referring and medical doctor information is important so that we may advise them of your eye condition and any medications we are prescribing.

REFERRING OPHTHALMOLOGIST NAME: _____

ADDRESS: _____

PHONE: (____) _____

MEDICAL DOCTOR (PRIMARY CARE) NAME: _____

ADDRESS: _____

PHONE: (____) _____

INSURANCE AUTHORIZATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare or any private health plan to : CORNEAL ASSOCIATES, P.C. This assignment is considered valid as an original. **I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.**

Date _____

Signature _____

INSURANCE INFORMATION/UPDATE

*Please note that we need **all** of this information in order to be able to bill your insurance company directly. Also, **please bring your insurance card to your appointment.** We will need to make a copy of it at that time.*

Primary Insurance Company Name: _____

Identification # _____

Group Number or Name _____

Complete Address of Commercial Ins Co. _____

_____ Phone: _____

Effective Date of Coverage: _____

Subscriber Name _____ *(If different from patient)*

Subscriber Birth date: _____

Subscriber Relationship to Patient SPOUSE PARENT/GUARDIAN

(please circle one)

Sex: MALE FEMALE *(please circle one)*

Secondary Insurance Company Name: _____

Identification # _____

Group Number or Name _____

Complete Address of Commercial Ins Co. _____

_____ Phone: _____

Effective Date of Coverage: _____

Subscriber Name _____ *(If different from patient)*

Subscriber Birth date: _____

Subscriber Relationship to Patient SPOUSE PARENT/GUARDIAN

(please circle one)

Sex: MALE FEMALE *(please circle one)*

Workman's Compensation

Company Name or Attorney's Name: _____

Claim Number: _____

Address: _____

Phone (____) _____

Adjuster's Name: _____

Date of Injury: _____