PATIENT REGISTRATION

Address Phone # (H) (W) (C)	Name	Social Security #	
Email Employer Occupation Spouse's Name Employer Parent's name if patient is a child INSURANCE INFORMATION Please present you insurance cards to the front desk and provide the following information: Name of Medical Insurance Name of Vision Insurance Name of Subscriber Employer Subscriber's Date of Birth SS# "I request that payment of authorized Medicare benefits and/or insurance benefits be made either to me or on my behalf to Bala Eye Care for any services furnished me by either physician of supplier. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed o determine these benefits payable for related services" "I also understand that my insurance company may or may not honor these charges, but that I am totally responsible for payment for any/all services regardless of insurance charges."			
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