PATIENT REGISTRATION

Name ____________________ Social Security # ____________________

Address ____________________ Phone # (H) ____________________

____________________ (W) ____________________

____________________ (C) ____________________

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."

Signature ____________________ Date ____________________