Eureka Springs EyecareClinic

"Helping You See Eye-to-Eye With Your Doctor"

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: _____ / _____ / _____

Name: Last _____ First _____ MI _____

Address: _____ City _____ State ____ Zip _____

Phone: Home _____ Work _____ Cell _____

Date of Birth ____ / _____ / _____ Age: _____ SSN: _____ Sex: M ____ F _____

Single _____ Married _____ Widowed _____ Spouse's Name: _____

Employer _____ Email _____

Emergency contact name number: _____

(Other than your own)

Primary Care Physician: _____ Did physician refer you? _____

How did you hear about us?

Doctor Referral: _____ Family / Friend Referral: _____ (name) _____

Phonebook: ____ Website: ____ Facebook: ____ Newspaper: ____ Radio: ____

Responsible Party

(If different than patient)

Name: Last _____ First: _____ MI _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Relationship to Patient: _____ SSN: _____

Employer: _____ DOB: _____

Please continue on other side.

Insurance Information

Primary Insurance Company

Name of Insurance: _____

Primary Cardholder: _____ Relationship to Patient: _____

Primary Cardholder Employer: _____ Work Phone: _____

Primary Cardholder Birthday: _____ SSN: _____

Secondary Insurance Company

Name of Insurance: _____

Primary Cardholder: _____ Relationship to Patient: _____

Primary Cardholder Employer: _____ Work Phone: _____

Primary Cardholder Birthday: _____ SSN: _____

Policies and Consents

HIPPA Consent Policy:

With my consent, Eureka Springs Eyecare Clinic may use and disclose my protected health information to carry out treatment, payment and healthcare operations. I understand that I have the right to review Eureka Springs Eyecare Clinic's Notice of Privacy Practices and have been given the opportunity to do so. With my consent, Eureka Springs Eyecare clinic may call my house or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, and insurance information among others.

Signature of Patient: _____ Date: _____

My private information can be released to the following persons:

_____

Payment and Insurance Policy:

Payment is due upon completion of today's visit. If you have insurance, we will be happy to process your claim, but request that you pay your estimated portion at the time of service. This includes co-pays, percentages and deductibles. We require that all insurance payments are hereby assigned to Eureka Springs Eyecare Clinic for services rendered to the patient or dependent. Charges denied due to insurance policy limitations will be transferred to the patient or guarantor. Payment for any treatment deemed by insurance not medically necessary is the responsibility of the patient.

Signature of Patient or Guardian: _____

Please Print name: _____ Date: _____