Barnet·Dulaney·Perkins
EYE CENTER

Patient Registration Form

Please use Black Ink only to fill out forms.

❑ Male ❑ Female ❑ ***Please check this box if you are a winter visitor. If so, please provide both addresses.***

❑ Mr. ❑ Mrs. ❑ MS. ***LEGAL*** Name: _____
Last *First* *MI* *Spouse*

Local Address: _____
Street APT# City State ***9 DIGIT ZIP***

Mailing Address: _____
Street APT# City State ***9 DIGIT ZIP***

Home Phone: _____ Cell Phone: _____ Alternate: _____
❑ *Work* ❑ *Day* ❑ *Other*

E-MAIL Address: _____
We do NOT share this information with anyone. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders

How would you prefer for us to communicate with you?
❑ *Phone (❍ home ❍ cell ❍ alternate)* ❑ *E-Mail*

Age: _____ Date of Birth ____/____/____ Social Security # _____

Responsible Party: _____

Date of Birth *(responsible party)* _____

Phone: _____ Relationship _____

Employer Name & Address: _____

_____

Occupation: _____

Emergency Contact: _____ Phone: _____
(Not in the same household)

MEDICAL INFORMATION:

Who is your Medical Doctor? _____

Address: _____ Phone _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Primary Address: _____ Insurance Phone: _____

Secondary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Secondary Address: _____ Insurance Phone: _____

Form continues ➔ ➔ ➔ ➔

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AUTHORIZATION AND RELEASE

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company and/or Medicare to pay directly to the doctor or doctor's group insurance or Medicare benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that I will be billed a fee for any returned checks.
- I understand that refractive consultations are offered as a free service for patients who intend to schedule a surgical procedure. In the event that a surgery is not scheduled, excluding the case of non-candidacy; if eyeglass prescription information is requested, a $90.00 charge will be incurred for the exam portion of the refractive consultation.
- I also request that the payment of authorized Medigap benefits or other secondary insurance be made either by me or on my behalf. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures

Signature of patient or parent, if minor	Date	Signature of witness

PLEASE NOTE: Most insurance policies do not cover refraction services.

How were you referred to our office?

❑ Doctor (Name: _____) ❑ Friend/Relative (Name: _____)
❑ Newspaper ❑ Radio/Television ❑ Internet ❑ Yellow Pages ❑ Reputation
❑ Website ❑ Insurance ❑ Social Media (ex. Facebook)
❑ Health Fair/Expo ❑ Drive By ❑ Previous Patient ❑ OTHER_____