Professional Eyecare Centers
REGISTRATION FORM

INTAKE DATE: _____ COMPLETED BY: _____

REFERRING PHYSICIAN: _____

PATIENT NAME: _____ **Date of Birth:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ EMPLOYER: _____

PHONE: _____ WORK PHONE: _____

SEX: Female Male MARITAL STATUS: Single Married Divorced

RESPONSIBLE PARTY: _____ SS# _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE: _____ DATE OF BIRTH: _____

INSURANCE #1: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ PHONE #: _____

INSURED DATE OF BIRTH: _____ SS#: _____

INSURANCE #2: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ PHONE #: _____

INSURED DATE OF BIRTH: _____ SS#: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized Professional Eyecare Centers billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Professional Eyecare Centers. If I have Medicare insurance, I authorize Professional Eyecare Centers to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Professional Eyecare Centers by written request.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____