SOUTHWESTERN EYE ASSOCIATES PATIENT REGISTRATION

PLEASE PRINT

PATIENT NAME____CELL PHONE___________________________

HOME PHONE_____________________________ EMAIL ____

ADDRESS____ CITY____________________STATE_____ZIP_______________

DATE OF BIRTH____________________________ AGE_________ SS#____

MALE______ FEMALE______ MARITAL STATUS_____________________ REFERRED BY __________________________________

PATIENT'S EMPLOYER _____________________________________ WORK PHONE ______________________________________

EMERGENCY CONTACT (OTHER THAN YOUR OWN RESIDENCE) NAME____

RELATIONSHIP____ PHONE____________________________________

PRIMARY INSURANCE COMPANY NAME ____

INSURED'S NAME____ RELATIONSHIP_____________________

INSURED'S DATE OF BIRTH ____

SS#___________________________________

INSURED'S EMPLOYER ____

SECONDARY INSURANCE COMPANY NAME ____

INSURED'S NAME____ RELATIONSHIP_____________________

INSURED'S DATE OF BIRTH ____

SS#___________________________________

INSURED'S EMPLOYER ____ **COPAY________________**

The above information is complete and correct. AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the physician, or group indicated on the claim. I understand that I am responsible for all fees, regardless of insurance coverage. In the event of collection proceeding due to a lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the physician. A copy of the signature is as valid as the original.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE