

# Patient Registration Form

Date		Account ID		Chart ID		Other ID		Internal Use	
<b>Patient Information</b>									
Last Name		First Name		Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address					Home:		How did you hear of us?		
Address 2					Work:				
					Cell:				
					Email:				
City		State	Zip Code		Employer Name & Address			Occupation	
Emergency Contact			Phone		Pharmacy			Pharmacy Phone	
<b>Physician</b>		<b>Family Physician</b>			<b>Referring Physician</b>				
<b>Medical Insurance</b>									
	Name & Address		Policyholder		Relationship	Policy ID	Group ID		
1									
2									
3									
<b>Guarantor (Person to be billed, if different than patient)</b>									
1	Last Name		First Name		Middle	Gender	Marital Status	Birthdate	Social Security #
Address					Home:		Work:	Email:	
City		State	Zip Code		Employer Name & Address			Occupation	
2	Last Name		First Name		Middle	Gender	Marital Status	Birthdate	Social Security #
Address					Home:		Work:	Email:	
City		State	Zip Code		Employer Name & Address			Occupation	
<b>HIPAA Approved Contacts</b>									
1.	Last Name		First Name		Middle	Gender	Birthdate	Social Security #	Relationship
Address			City		State	Zip Code	Home:	Cell:	Work:
2.	Last Name		First Name		Middle	Gender	Birthdate	Social Security #	Relationship
Address			City		State	Zip Code	Home:	Cell:	Work:
<b>Patient's or Authorized Person's Signature</b>									
<p>I the undersigned give my authorization to treat and assign directly to Main Line Eye Specialists, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.</p> <p>I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.</p>									
Signature			Signature Date			<b>MAIN LINE EYE SPECIALISTS</b> 124 Bloomingdale Avenue, Wayne, PA 19087 Phone: 610-687-6888 Email :			
X									
<b>Please attach all pertinent insurance ID cards for photocopying.</b>									