Patient Registration

Patient Name: _____

SSN: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: _____ ☐Home ☐Cell ☐Other

Alternate Phone Number: _____ ☐Home ☐Cell ☐Other

E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Employer: _____ Work Number: _____

Work Address: _____

Spouse or nearest relative: _____ Relationship to patient: _____

Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Referring Physician: _____

Family Physician: _____

Pharmacy Name/Location: _____

Patient's Medicare, Medica and Supplemental Lifetime Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Barnett Vision Clinic for any services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

AUTHORIZATION: I hereby authorize any insurance benefits to be paid directly to Barnett Vision Clinic and acknowledge that I am financially responsible for any unpaid balance. If my account is sent to a collection agency for non-payment, I will be responsible for any collection fee. We will complete and file your insurance forms at no charge as a courtesy to you. It is your responsibility to provide all your current insurance information. We will make every effort to help understand your coverage.

AUTHORIZATION: I authorize Barnett Vision Clinic to release necessary medical information to insurance carriers and to referring physicians concerning my health care and treatments.

I have read and understand the Health Information Practices of Barnett Vision Clinic.

_____ _____

Patient's Signature Date