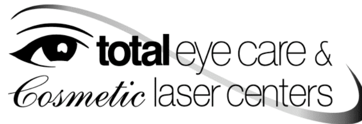

Patient Registration – CONFIDENTIAL INFORMATION

***** IMPORTANT: PLEASE COMPLETELY PRINT THE FOLLOWING *****

LAST Name ____

FIRST Name ______________________________ **Middle Initial** _____

Male or **Female** **DOB**: ___/___/____ **SSN**: ______-_____-______

Address ____

City __________________________ **State** _____ **Zip** _________

Home Phone (_____) _____ - ____________________________

Work Phone (______) _____ - ____________________________

Mobile Phone (______) _____ - ____________________________

E-Mail ____

Marital Status Single Married Life Partner Divorced Widowed

HOW DID YOU HEAR ABOUT US? ____________________________

GUARDIAN Last Name ______________________________________

GUARDIAN First Name ______________________Middle Initial________

Family Member or Friend in PA or NJ that are not living with you. In case of EMERGENCY, the following person should be notified:

EMERGENCY Contact Name __________________________________

EMERGENCY Contact Relationship ____________________________

EMERGENCY Contact Phone (_____) _____- _____________________

PATIENT EMPLOYER NAME: _________________________________

PATIENT Employer Phone (_____) _____- _______________ x ______

** PLEASE COMPLETE GUARANTOR & INSURANCE INFORMATION **
** ON OTHER SIDE OF THIS FORM **

GUARANTOR INFORMATION

Patient's Relationship to Guarantor:

Self Spouse Child Parent Life Partner Other: _____________

GUARANTOR (Name to Whom Statements are Sent)

GUARANTOR Last Name ____

GUARANTOR First Name _________________________ Middle Initial ______

GUARANTOR Address (If Different From Patient's)

Street ____

City _________________________________ State ______ Zip __________

GUARANTOR SSN: __________ - ________ - ___________

GUARANTOR Phone (______) _______ - ______________________________

GUARANTOR Employer: ____

INSURANCE INFORMATION

HAVE NO INSURANCE/SELF PAY

Primary Care Physician: ____

Primary Care Telephone Number: (_____) ___________________________

PRIMARY Insurance Carrier ____

Policyholder Name __________________________DOB _____/____/_______

Patient's Relationship to Policyholder:

Self Spouse Child Parent Life Partner Other: _____________

Primary Ins ID# ___________________________ Group #________________

SECONDARY Insurance Carrier _____________________________________

Policyholder Name __________________________DOB _____/____/_______

Patient's Relationship to Policyholder:

Self Spouse Child Parent Life Partner Other: _____________

Secondary Ins ID# ________________________ Group # _________________

I request that payment of authorized Medicare and/or other insurance benefits be made either to me or on my behalf to **TOTAL EYE CARE CENTERS PC** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare Services (CMS) and its agents or other agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT or GUARANTOR ____

Signature

Date Signed _____/_____/_______

Rev 9-2008