PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME: _____

FIRST NAME: _____

CHECK ONE: ☐MR. ☐MRS. ☐MS. ☐MISS ☐M.D.

MARITAL STATUS: S M D W
(CHECK ONE)

ADDRESS: _____

STATE:_____ ZIP:_____

TELEPHONE HOME: ( ) _____

WORK: ( ) _____

E-MAIL ADDRESS: _____

DATE OF BIRTH:_____
MONTH DAY YEAR

SOCIAL SECURITY NO.: _____

SEX: ☐ MALE ☐ FEMALE RACE:_____

EMPLOYER: _____

ADDRESS: _____

OCCUPATION OF PATIENT:_____

SPOUSE'S NAME_____

Are you covered under your spouse's insurance? ( ) YES ( ) NO

PARENT/GUARDIAN _____
(IF MINOR)

ADDRESS (IF DIFFERENT):_____

WHO REFERRED YOU TO OUR PRACTICE?

NAME: _____

ADDRESS: _____

*UPDATE:*_____
Sign and Date

TODAY'S DATE: _____
MONTH DAY YEAR

INSURANCE INFORMATION

DO YOU HAVE? (CHECK APPROPRIATE BOXES)

1. PRIMARY _____

ID#_____

GROUP# _____

SUBSCRIBER _____DOB_____

RELATIONSHIP TO APPLICANT/SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

2. SECONDARY_____

ID#_____

GROUP# _____

SUBSCRIBER _____DOB_____

RELATIONSHIP TO APPLICANT/SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

ADDRESS OF APPLICANT/SUBSCRIBER

_____

_____

IF PATIENT IS A MINOR, WHO MAY AUTHORIZE TREATMENT OF PATIENT?

_____

_____

HIPPA PRIVACY ACT

WHO MAY WE RELEASE MEDICAL INFORMATION TO?

_____

_____

_____

MEDICAL INFORMATION WILL ONLY BE RELEASED TO THOSE PERSONS LISTED ABOVE, IN ADDITION TO THE HIPAA GUTDELINES FOR THE RELEASE OF HEALTH INFORMATION.

*UPDATE:*_____
Sign and Date

AUTHORIZATIONS FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

MEDICARE
I request that payment of authorized Medicare benefits be made on my behalf to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished me by the physicians. 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 benefits payable for related services.

DATE:_____ SIGNED: _____

MEDIGAP
I request that payment of authorized Medigap benefits be made on my behalf to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to Medigap insurer any information needed to determine these benefits payable for related services.

DATE:_____ SIGNED: _____

OTHER INSURANCE
I, the undersigned, authorize payment of medical benefits to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished to me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

DATE:_____ SIGNED: _____

WORKMEN'S COMPENSATION
The services and treatment you receive from our physicians may have resulted from an injury or illness which is job related and is covered by Worker's Compensation. If this is true, it is your responsibility to report your injury and/or illness directly to your employer. You must also inform us at the time of each visit that you are a Worker's Compensation case, and furnish us the name and address of your employer or the insurance carrier who covered your company.

I hereby authorize my insurance benefits to be paid directly to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. and I am financially responsible for "non-covered services." I also authorize the physician to release any information required to process this claim.

DATE:_____ SIGNED: _____

PATIENT RESPONSIBILITY
I understand that I am financially responsible for any amounts that are due from me. If my account is uncollectible through normal means, a collection agency referral will be made and I will be responsible for all collection fees in addition to the outstanding balance on my account.

DATE:_____ SIGNED: _____