PATIENT REGISTRATION FORM

Patient Information

LAST NAME	FIRST	MI	☐ MALE ☐ FEMALE	BIRTHDATE	AGE	HOME PHONE
ADDRESS			SOCIAL SECURITY	MARITAL STATUS	CELL PHONE	
CITY	STATE	ZIP	EMAIL			
EMPLOYED? ☐ YES ☐ NO	EMPLOYER NAME		OCCUPATION			
EMPLOYER ADDRESS					WORK PHONE	
EMERGENCY CONTACT			RELATIONSHIP TO YOU		PHONE	

Insurance

INSURANCE COMPANY (PRIMARY)	EFFECTIVE DATE		INSURANCE COMPANY (SECONDARY)	EFFECTIVE DATE	
ADDRESS (FOR CLAIMS TO BE SENT TO)			ADDRESS (FOR CLAIMS TO BE SENT TO)		
CITY	STATE	ZIP	CITY	STATE	ZIP
POLICY ID #	GROUP #	PHONE #	POLICY ID #	GROUP #	PHONE #
POLICY HOLDER			POLICY HOLDER		
SOCIAL SECURITY			SOCIAL SECURITY		
DATE OF BIRTH	SEX: ☐ MALE ☐ FEMALE		DATE OF BIRTH	SEX: ☐ MALE ☐ FEMALE	
RELATIONSHIP TO YOU			RELATIONSHIP TO YOU		

Workmen's Comp

IS THIS INJURY WORK RELATED?	DATE OF INJURY	DOES YOUR EMPLOYER KNOW?
IF YES, WORMEN'S COMP. INS. CARRIER NAME & ADDRESS (WHERE TO SEND CLAIMS) CITY, STATE, ZIP		PHONE
EMPLOYER NAME & ADDRESS (WHERE INJURY OCCURRED) CITY, STATE, ZIP	INSURANCE CLAIM #	EMPLOYEE POLICY #

REFERRING PHYSICIAN _____

ADDRESS _____

PHONE _____

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

I hereby assign or transfer payment benefits made to me or on my behalf to **EYECARE CONSULTANTS OF NJ, PA** for any services furnished by this physician/supplier. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance has paid me.

I hereby authorize **EYECARE CONSULTANTS OF NJ, PA** to release information aquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Health Care Financing administration and its agents any information needed to determine benefits payable for related charges.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____