PATIENT REGISTRATION FORM

DATE: ______/______/______ PATIENT NAME: ____

ADDRESS: ____

STREET CITY STATE ZIP CODE

PHONE: Home: ________________________ Work: _______________________ Cell: ________________________

SEX: M F AGE: ________ BIRTHDATE: ______/______/______ Email: _____________________________

SOCIAL SECURITY#: ______-______-_______ EMPLOYER: ____

MARITAL STATUS: Single _____ Married _____ Divorced _____ Widowed _____

RESPONSIBLE PARTY: ____

Name (please print) Relationship to Patient

ADDRESS: ____

STREET CITY STATE ZIP CODE

PHONE: Home: ________________________ Work: ________________________ Cell: ______________________

INSURANCE: MEDICARE Y N Medicare# ____

MEDICAL ASSISTANCE Y N MA# ____

INSURANCE CO: ____ ID# ___________________________________

SUBSCRIBER NAME: ____ GROUP# ____________________

SUSCRIBER: Social Security # _______ _______ ________ Date of Birth: ______/______/______

Employer: ____ Relationship to patient: ________________________

OTHER INSURANCE: ______________________________________ ID# ___________________________________

SUBSCRIBER NAME: ____ GROUP# ___________________

SUSCRIBER: Social Security # _______ _______ ________ Date of Birth: ______/______/______

Employer: ____ Relationship to patient: ________________________

Authorization To Pay Benefits To Physician: I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Chippewa Valley Eye Clinic Ltd for any equipment or services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits for related equipment or services to the organization, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage.

HIPAA Notice: Chippewa Valley Eye Clinic's Notice of Privacy Practice is available at **www.cv-eye.com/Patient-forms** .
I acknowledge that a printed version is also available at my request.

_______________________________________ _________________________ _________________________

Signature (Patient or Guardian) Relationship to Patient Date

I grant the following person(s) permission to speak with Chippewa Valley Eye Clinic regarding my medical records and treatment.

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

*******BRING THESE COMPLETED FORMS TO YOUR APPOINTMENT*******