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IOWA EYE CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Name _____
LAST FIRST MI

Sex: Male Female Marital Status M D S W

Birthdate _____ Age _____ Billing Address _____
(if different than patient address)

Social Security Number _____
CITY STATE ZIP

Address _____
CITY STATE ZIP

Spouse's or Parent Name _____

Spouse's or Parent Employer _____

Spouse's or Parent Work Ph. _____

Spouse's or Parent SS# _____

Spouse's or Parent Date of Birth _____

Employer _____

Close friend or relative _____ Phone No. _____
(not living at your address)

Family Doctor Name _____

Location (Name of Clinic, Town, Etc.) _____

DEMOGRAPHICS

INSURANCE AND BILLING INFORMATION:

PLEASE SHOW YOUR CURRENT INSURANCE CARD SO WE CAN MAKE A
PHOTOCOPY FOR OUR RECORDS

If you have Medicare:

- Are you (or your spouse) currently working? YES NO
- Are you receiving benefits under an employer's disability policy? YES NO
- Do you have end stage renal disease? YES NO

We will gladly file insurance claims with the information provided by your current insurance card.

Although we are happy to assist you in complying with the regulations of your insurance company it is ultimately your personal responsibility to be knowledgeable of these rules and inform us of any special requirements.

SIGNATURE ON FILE:

I request that payment of authorized insurance benefits be made on my behalf to Iowa Eye Center for any services furnished me by any physician/supplier within this office.

I authorize any holder of medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits or benefits payable for related services.

I understand that I remain financially responsible for all medical fees incurred for services rendered by Iowa Eye Center.

X _____
Patient or Authorized Representative Date

This authorization applies to all occasions of service until it is revoked in writing.

