Patient Registration Chart:

Name: _____
DOB: _____ Age: _____ Gender: _____
Date: _____ Office: _____

Patient Information

Account # _____ **Patient Name**	**Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Social Security Number | **Driver's License**	
Address	**Patient Sex**
City, State & Zip Code ,	**Date of Birth** _____ **Age** _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** _____ **Relationship to Patient:** _____
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** _____ _____ **Occupation:**
Referring Physician: _____ **Family Physician:** _____	**Email Address (please print)** _____ **Married** ☐ **Single** ☐ **Other** ☐ **Spouse's Name**
Patient Smoking Status: ☐ **Current Everyday Smoker** ☐ **Current Someday Smoker** ☐ **Smoker, current status Unknown** ☐ **Never Smoker** ☐ **Former Smoker** ☐ **Unknown if ever Smoker** **Ethnicity of Patient:** ☐ **Hispanic Origin** ☐ **Non Hispanic Origin** ☐ **Unknown** ☐ **Declined to answer**	**Race of Patient:** ☐ **American Indian/ Alaskan Native** ☐ **Asian** ☐ **Black/ African American** ☐ **Native Hawaiian/ Other Pacific Islander** ☐ **White** ☐ **Unknown** ☐ **Declined to answer** **Preferred Language of Patient:** ☐ **English** ☐ **Spanish** ☐ **Other** _____

In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above)

Full Name _____ **Address** _____ **City, State & Zip Code** _____ **Date of Birth** _____	**Social Security Number** _____ **Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Employer Name _____	**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

Patient Registration Chart:

EYE PHYSICIAN ASSOCIATES S.C.

Name: _____
DOB: _____ Age: _____ Gender: _____
Date: _____ Office: _____

Insurance Company Information

Primary Insurance Company Name		**Secondary Insurance Company Name**	
Address, City, State & Zip		**Address, City, State & Zip**	
Policy Holder	**Date of Birth**	**Policy Holder**	**Date of Birth**
Policy Holder Employer	**Policy Holder SSN**	**Policy Holder Employer**	**Policy Holder SSN**
Policy Number	**Group Number**	**Policy Number**	**Group Number**
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Vision Plan Name	**GUARDIAN AND/OR HOSPICE CARE INFORMATION**
Address, City, State & Zip	1. Does someone have Power of Attorney (POA) or legal guardianship for you? ☐ Yes ☐ No
Policy Holder **Date of Birth**	If you answered "Yes", please provide us with the contact for the POA/Guardian. Eye Physician Associates also needs a copy of the POA or legal guardianship paperwork if this applies.
Policy Holder Employer **Policy Holder SSN**	
Policy Number **Group Number**	Legal Guardian Name: _____
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	Phone: _____

I heard about this clinic from *(check all that apply):*

☐ Referring Doctor ☐ Walk-In ☐ Friend/Family: _____
☐ Radio ☐ Magazine/Newspaper ☐ Patient: _____
☐ Event or Exhibit ☐ Mailing ☐ Other: _____
☐ Internet ☐ TV ☐ Social Security/Disability

I hereby authorize Eye Physician Associates, S.C. to release to the insurance company/companies listed on this form any information acquired in the course of my examination and/or treatment and to receive all payments for such examination and/or treatment. If you are covered by insurance, we will submit charges to the insurance company on your behalf. Co-pays are to be paid at the time the services in rendered. I understand that I am financially responsible for any portion not covered by the above insurance(s).

X _____ _____
Signature of Patient Date