CONCORD EYE CENTER

PATIENT REGISTRATION

Name:	Account No:	Marital Status (Please Circle): S M W D	Date of Birth:	Sex:
Address: STREET	CITY	STATE	ZIP	
Home Telephone:	Other Telephone (i.e. Work, Cell): W: C:	Primary Care Physician:		
Emergency Contact: NAME	TELEPHONE #	RELATIONSHIP		
Employer Name:	E-mail Address			
How did you hear of our office?				

HIPAA – Disclosure of Information

If you would like us to be able to discuss your eye care with anyone other than yourself, please list the name, relationship and telephone number below.

Name:	Telephone Number:	Relationship:
Name:	Telephone Number:	Relationship:

I have been offered a copy of or have read Concord Eye Center's "Notice of Privacy Practices." **Your Initials _________**

GUARANTOR INFORMATION (Parent/Guardian for patients under 18)

Name:	Date of Birth:	
Address:		
Home Telephone:	Guarantor's Employer:	
Power of Attorney (If Applicable): NAME	ADDRESS	TELEPHONE NUMBER

INSURANCE INFORMATION

Primary Insurance:	Certificate Number:
Subscriber:	Group Number:
Subscriber Employer:	Subscriber Date Of Birth
Relationship To Subscriber:	

Secondary Insurance:	Certificate Number:
Subscriber:	Group Number:
Group Employer:	Subscriber Date Of Birth
Relationship To Subscriber:	

I have received and understand the practices financial policy. **Your Initials _________**

INSURANCE AUTHORIZATION AND CONSENT

I hereby authorize Concord Ophthalmologic Associates, d.b.a. Concord Eye Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance.

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SIGNATURE (PATIENT OR REPRESENTATIVE) DATE