PALM COAST EYE PHYSICIANS

PATIENT REGISTRATION

Today's Date: _____ Account #: _____

Patient's Legal Name: _____
Last First M

Sex: ___F ___M Date of Birth: ____/____/____

Social Security #: _____Driver's License #_____

Home Address:_____
Street City State Zip

Home Phone: _____Work / Cell Phone:_____

If patient is a minor: Mother's name:_____Father's name:_____

Occupation:_____Employer:_____

Employer's Address:_____

SPOUSE OR PARENT/GUARDIAN INFORMATION

Name: _____Relationship:_____
Last First M

Address:_____
Street City State Zip

Home Phone: _____Work / Cell Phone:_____

Occupation:_____Employer:_____
Employer's Address:_____

REFERRING DOCTOR/PRIMARY DOCTOR INFORMATION

Referring Physician: _____Phone:_____

Primary Care Physician:_____Phone:_____

PRIMARY INSURANCE

Primary Insurance: _____Phone Number:_____

Policy/ID #: _____Group Number:_____

Name of Policy Holder:_____Relationship:_____

Policy Holder SS #:_____Policy Holder D.O.B.:_____

Policy Holder Employer:_____

SECONDARY INSURANCE

Secondary Insurance: _____Phone Number: _____

Policy/ID #: _____Group Number: _____

Name of Policy Holder:_____Relationship:_____

Policy holder SS #:_____Policy Holder D.O.B.:_____

EMERGENCY INFORMATION
Please list a friend or relative (not of the same address) to contact in case of any emergency

Name:_____Relationship:_____
Last First M

Address:_____
Street City State Zip

Phone: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I authorize **Palm Coast Eye Physicians** to release any medical information necessary to process health insurance claims.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS
I authorize payment of medical benefits applicable to services cited on the claim form to **Palm Coast Eye Physicians**.

CONSENT FOR TREATMENT
This consent is valid during the entire term of my association with **Palm Coast Eye Physicians** and may be relied upon by **Palm Coast Eye Physicians**, unless, and until, revoked by patient or those acting for patient, in writing.
Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician (s) in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office. If a biopsy is deemed necessary, I hereby authorize **Palm Coast Eye Physicians** to send a biopsy specimen to a suitable laboratory for a pathology report.

GUARANTEE OF ACCOUNT
I hereby authorize **Palm Coast Eye Physicians** to provide such information as may be required by state or federal agencies or my insurance company, and for and in consideration of the services rendered to patient, we, the undersigned , jointly or severally, promise to pay to **Palm Coast Eye Physicians** the full amount of charges for such services, on demand, or by such future date as may be determined by **Palm Coast Eye Physicians**. I understand that my bill will be due and payable in full on or before such date. In the event of default, I agree to pay a reasonable attorney fee and costs.

Signature:_____Date:_____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name:_____Relationship_____