

# Little Rock Eye Clinic

## PATIENT REGISTRATION

SCANNED

Day Time Phone Number \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Single Married Divorced Widowed

Address: Street \_\_\_\_\_ No.: \_\_\_\_\_ Sex:  M  F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

PERSONS TO CONTACT IN CASE OF EMERGENCY:	RELATIONSHIP	TEL. NUMBER

EMPLOYER: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ NAME OF SUPERVISOR: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**FINANCIAL INFORMATION:**

**REFERRAL:** If my insurance policy requires a referral number from my Primary Care Physician or any Referring Physician and Little Rock Eye Clinic does not receive this number, I will be responsible for charges.

Name of Responsible Person: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID / Policy No. \_\_\_\_\_  
 / \_\_\_\_\_

Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID / Policy No. \_\_\_\_\_  
 / \_\_\_\_\_

Address: \_\_\_\_\_

CO-PAYS: I AGREE TO PAY CO-PAYS ON THE DATE OF SERVICE \_\_\_\_\_ VISION INSURANCE:  YES  NO

I, the undersigned, hereby authorize Little Rock Eye Clinic, its physicians and/or agents to apply for benefits on my behalf for services rendered to me. I request payment from my insurance carrier to be made directly to Little Rock Eye Clinic. I certify that the above information is correct and further authorize the release of any information for any claim to my insurance carrier. I understand the HIPPA compliance regulations and agree to them. I also authorize Little Rock Eye Clinic, its physicians and agents to disclose any part of or all of the medical records to my insurance carrier. I also understand that it may be necessary to contact my present or past employer(s) in regard to insurance claims.

**GUARANTEE OF PAYMENT / NON-COVERED CHARGES:**

I, the undersigned, understand that I am financially responsible for all charges including those not covered by my health insurance and/or Medicare. I further understand that Medicare and/or my health insurance company may not cover all services rendered, such as refractions, routine eye exams, eyeglasses and other ancillary testing. Charges for these services may be obtained prior to the examination I understand if Medicare and/or my insurance company deny services, then it will be my responsibility to pay for these charges.

**PRIVACY POLICY:** I acknowledge that I have received and understand Little Rock Eye Clinic's Privacy Policy.

NO CHANGE SINCE LAST VISIT

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

*Minors cannot sign this form. A minor's parent or guardian must be present to give consent to treatment, the purchase of eyewear, payment of service and authorization release medical information.*

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_