WELCOME

REGISTRATION FORM

Please fill out completely. Insurance may not pay if we cannot provide all this infomation.
If a question is not applicable, please enter N/A.

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ M.I. ________

Mailing Address ______________________ City ______________ State _______ Zip Code ________

Patient Numbers:

Home ______________________ Work ______________________ Cell ______________________

Social Security # ______________________ Date of Birth ______________ Sex: Male / Female (circle one)

Marital Status: 1) Single ________ 2) Married ________ 3) Divorced ________ 4) Widowed ________ 5) Legally Separated ________

Race: 1) Asian ________ 2) Caucasian ______ 3) Hispanic ________ 4) Indian ________ 5) African American ________

Physician You Are Seeing Today: (Circle One)

Beall Bochow Frazier Kiblinger Mack
Pennell Prater Schreiber Wick

Referring Physician ______________________ Primary Care Physician ______________________

PERSON RESPONSIBLE FOR THE BILL ***(ONLY APPLICABLE IF OTHER THAN THE PATIENT)***

Last Name ______________________ First Name ______________________ M.I. ________

Mailing Address ______________________ City ______________ State _______ Zip Code ________

Home Phone # ______________ Work Phone # ______________ Ext ________ Relationship to Patient ____________

INSURANCE INFORMATION ***(PLEASE LIST POLICY HOLDER IF OTHER THAN PATIENT)***

Primary Insurance Company: ______________________________ Policy # ______________

Address ______________________________ Group # ______________

Policy Holder ______________________ Relationship to Patient ______________ Effective Date ______________

Date of Birth ____________ Sex ______ Social Security # ______________ Employer ______________

Other Insurance Company: ______________________________ Policy # ______________

Address ______________________________ Group # ______________

Policy Holder ______________________ Relationship to Patient ______________ Effective Date ______________

Date of Birth ____________ Sex ______ Social Security # ______________ Employer ______________

ADDITIONAL PATIENT INFORMATION E-Mail Address ______________________

Emergency Contact ______________________ Phone # ______________ Relationship to Patient ____________
(relative not living with you, neighbor or friend)

How Did You Hear About EyeCare Associates?

1) Friend/Family (Name) ______________________ 2) TV ________ 3) Radio ________ 4) Newspaper ________

5) Yellow Pages ________ 6) Website ________ 7) Doctor ________ Other ______________________

Student: Full Time ____________ Part Time ____________ D.L. # ______________________

Has anyone in your household been here before? ___ Yes ___ No

- OVER -

ECA Initials _______

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of East Texas physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend EyeCare Associates of East Texas clinics, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer.

I understand that I may revoke this authorization for the release of information at any time, by providing written notice to EyeCare Associates of East Texas, except to the extent that action has been taken in reliance on it.

RELEASE OF LIABILITY: I release and agree to hold harmless EyeCare Associates of East Texas and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization.

I understand EyeCare Associates of East Texas cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of EyeCare Associates of East Texas. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges, to the providers of EyeCare Associates of East Texas. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by EyeCare Associates of East Texas.

REFRACTION: I understand that refraction (measurement of eyes for glasses / contacts) is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

______________________________	______________________________
Patient/Other Legally Authorized Person	Witness
______________________________	______________________________
Printed Name and Relationship to Patient	Date