

ST. PAUL EYE CLINIC, P.A. • REGISTRATION INFORMATION

Please Print

(Office Use Only)

RP Number _____ Patient Account No. _____ Receptionist _____
 Chart Number _____ 1 7 Dr. _____ Appointment Date _____
 2 9
 3 17

PATIENT INFORMATION

Have you or any member of your family ever been seen by a St. Paul Eye Clinic physician before? Yes No

Name _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)
 Sex _____ Social Security # _____ Marital Status _____ Employer _____ Occupation _____
 Apt. No. _____ Street Address _____
 City, State, Zip _____ Home Telephone _____ Work Telephone _____
 Referred by (Doctor) _____ Primary Care Doctor _____

PARTY RESPONSIBLE FOR ACCOUNT PAYMENT

(If other than patient)

Name _____ Relationship to Patient _____
(LAST) (FIRST) (MIDDLE INITIAL)
 Apt. No. _____ Street Address _____
 City _____ State _____ Zip _____
 Home Telephone _____ Work Telephone _____

INSURANCE INFORMATION

Please present insurance card to receptionist

PRIMARY INSURANCE COMPANY

Group Number _____ Identification Number _____

Policy Holder Information:

Name _____ Sex _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)
 Social Security # _____ Employer _____ Work Telephone _____
 Apt. No. _____ Street Address _____
 City _____ State _____ Zip _____

SECONDARY INSURANCE COMPANY

Group Number _____ Identification Number _____

Policy Holder Information:

Name _____ Sex _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)
 Social Security # _____ Employer _____ Work Telephone _____

RECORDS RELEASE: I hereby authorize the release of any information by ST. PAUL EYE CLINIC, P.A. to my referring doctor, insurance company, and immediate family on behalf of myself and/or dependents.

Date: _____ *SIGN _____
(A COPY OF THIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS AN ORIGINAL) (RELATIONSHIP)

ASSIGNMENT OF BENEFITS: I hereby authorize payment for Benefits to ST. PAUL EYE CLINIC, P.A. for services rendered to myself and/or dependents. Please note: Refraction charges may not be covered by your insurance carrier.

Date: _____ *SIGN _____
(A COPY OF THIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS AN ORIGINAL) (RELATIONSHIP)

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to ST. PAUL EYE CLINIC, P.A. for any services furnished me by that clinic. I acknowledge that Medicare determines refractions to be a non-covered service. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date: _____ *SIGN _____
(A COPY OF THIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS AN ORIGINAL) (RELATIONSHIP)

CHART # _____