

FOLEY EYE CLINIC, P.A.

REGISTRATION INFORMATION

| |
|---|
| Account # <small>For Internal Use</small> |
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|-------------------------------------|
| Referring/Primary Physician: |
|-------------------------------------|

| |
|---------------------------|
| Physician Phone #: |
|---------------------------|

PATIENT INFORMATION

| | | | | | |
|---------------|------------|--------|-----------|--|---|
| LAST NAME | FIRST NAME | MI | BIRTHDATE | SOCIAL SECURITY # | |
| HOME ADDRESS | | | CITY | STATE | ZIP |
| | | | | | SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| SPOUSE'S NAME | HOME # | CELL # | WORK # | MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED | |

EMPLOYMENT INFORMATION

| | | |
|---|------------------------|---|
| PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT: | OCCUPATION (Job Title) | EMPLOYMENT OR STUDENT STATUS: |
| | | <input type="checkbox"/> FULL-TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> PART-TIME <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> ACTIVE MILITARY |
| PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS: | CITY | STATE |
| | | ZIP |

EMERGENCY INFORMATION

| | |
|---|-------------------|
| NEXT-OF-KIN (For Emergency – Other than spouse) | RELATIONSHIP |
| NEXT-OF-KIN ADDRESS | CITY |
| | STATE |
| | ZIP |
| | NEXT-OF-KIN PHONE |

RESPONSIBLE PARTY INFORMATION

| | | | | | |
|------------------------------------|------|-------|------------------------|------------------------------|---|
| RESPONSIBLE PARTY NAME | LAST | FIRST | MI | RESPONSIBLE PARTY HOME PHONE | |
| RESPONSIBLE PARTY ADDRESS | | | CITY | STATE | ZIP |
| | | | | | RESPONSIBLE PARTY SOCIAL SECURITY # |
| RESPONSIBLE PARTY EMPLOYER | | | OCCUPATION (Job Title) | | RESPONSIBLE PARTY WORK PHONE |
| RESPONSIBLE PARTY EMPLOYER ADDRESS | | | CITY | STATE | ZIP |
| | | | | | RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER |

INSURANCE INFORMATION

| | | |
|---------------------|-----------------------|---------------|
| PRIMARY INSURANCE | CARDHOLDER | DATE OF BIRTH |
| GROUP NUMBER | IDENTIFICATION NUMBER | |
| ADDRESS | CITY | STATE |
| | | ZIP |
| | PHONE | |
| SECONDARY INSURANCE | CARDHOLDER | DATE OF BIRTH |
| GROUP NUMBER | IDENTIFICATION NUMBER | |
| ADDRESS | CITY | STATE |
| | | ZIP |
| | PHONE | |

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Foley Eye Clinic, P.A. of any medical benefits otherwise payable to me for the services provided at Foley Eye Clinic, P.A.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

 X
 Patient Signature or Signature of Guardian or Parent _____ Date _____

RECORDS RELEASE

I hereby authorize Foley Eye Clinic, P.A. to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

 X
 Patient Signature or Signature of Guardian or Parent _____ Date _____

FOLEY EYE CLINIC PA
FORM 23005
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

NAME OF INDIVIDUAL

This is to acknowledge receipt of a copy of **Foley Eye Clinic PA's** Notice of Privacy Practice with an effective date of ____/____/____ (mm/dd/yy).

Individual's (or Legal Representative's) Name:

Individual's (or Legal Representative's) Signature:

Date: _____

Capacity or Authority of Legal Representative (if applicable) *:

*May be requested to provide verification of representative status.

RECORDS TRANSFER FORM

I direct that all of my records be transferred from Progressive EYE-CARE Associates, P.A. to Foley Eye Clinic, P.A.

Patient Signature: _____

Date: _____