FOLEY EYE CLINIC, P.A.
REGISTRATION INFORMATION

Account # *For Internal Use*	**Referring/Primary Physician:**	**Physician Phone #:**

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #		
HOME ADDRESS		CITY	STATE	ZIP	SEX: ❑ MALE ❑ FEMALE	
SPOUSE'S NAME	HOME #	CELL #	WORK #	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED		

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:			OCCUPATION (Job Title)	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS:	CITY	STATE ZIP		❑ FULL-TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ PART-TIME ❑ SELF EMPLOYED ❑ ACTIVE MILITARY

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 ❑ SELF ❑ SPOUSE ❑ SON ❑ 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

2/15/12

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: _____
