Patient Registration Form

FOLEY EYE CLINIC, P.A.

Appt Date/Time: _____ Chart # _____

PATIENT INFORMATION

***First Name** **Middle Name** **Last Name**

***Address** **Address Line 2** **City** **State** **Zip Code**

Email ***Preferred Language** ***SSN** ***Date of Birth**

Driver's License **State** ***Primary Phone** **Phone Type** **Secondary Phone**

***Employer Name** ***Employer Phone** ***Employment Status (circle one)**
☐ F/T ☐ P/T ☐ Retired ☐ Student ☐ Not employed

***Emergency Contact Name** ***Emergency Contact Phone** ***Relationship to Patient**

Referring Physician* **Phone Number** **Primary Physician*** **Phone Number**

*INSURANCE INFORMATION

***Primary Insurance** ***Member # (ID)** ***Group#**

***Primary Insured Name** ***SSN** ***Relationship** ***Date of Birth**

Secondary Insurance **Member # (ID)** **Group#**

Secondary Insured Name ***SSN** ***Relationship** ***Date of Birth**

*FINANCIAL RESPONSIBILITY INFORMATION

Responsible Party Name **SSN** **Relationship to patient** **Primary Phone**

Address **Address Line 2** **City** **State** **Zip Code**

PREFERRED PHARMACY

Pharmacy Name **Pharmacy Phone** **Pharmacy Address**

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 service provided at Foley Eye Clinic, P.A.

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

X

Patient Signature or Signature of Parent/Guardian 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 for as long as charges are being submitted for insurance claim processing or for as long as dictated by the payor.

X

Patient Signature or Signature of Parent/Guardian Date

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

This is to acknowledge receipt of a copy of Foley Eye Clinic, P.A.'s Notice of Privacy Practice with an effective date of _____/_____/_____ (MM/DD/YY)

Patient (or Legal Representative's) Signature:

_____

Date: _____

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

_____

You may be requested to provide verification of representative status.

_____

OVER