

Registration :

20 20 Eye Care PC

Date	Account ID	Chart ID	Other ID	Internal Use
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Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact			Phone		Pharmacy		Pharmacy Phone

Physician	Family Physician	Referring Physician
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Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)							
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation

HIPAA Approved Contacts							
1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:

LANGUAGE-- English, Spanish, Other
ETHNICITY-- Hispanic, Non-Hispanic, Decline
RACE-- African American, American Indian, Asian, White, Decline

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to 20 20 Eye Care PC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	20 20 Eye Care PC	Phone: 781-501-5650
X		91 B Central Street Norwood, MA 02062	Email:

Please attach all pertinent insurance ID cards for photocopying.