PATIENT REGISTRATION

PATIENT INFORMATION: ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss ❒ Dr. **Race/Ethnic Group:**_____

❒Male ❒Female ❒ Married ❒Single ❒Widowed **Birthdate:** ____ /____ /____ **Age:**_____

Patient Name:_____
FIRST MI LAST

Home Address:_____
NO & STREET APT No CITY STATE ZIP

Home Phone: ( ) _____ Other Phone: ( )_____
Circle: Pager Mobile Fax

Work Phone: ( ) _____ Ext: _____ Employer:_____

Occupation: _____ Social Security #: _____ - _____ -_____

VERY IMPORTANT: Name and phone number of nearest relative(s) and/or friend to contact in case of emergency or appointment changes:

Name:_____ Phone: ( ) _____ Relation:_____

Name:_____ Phone: ( ) _____ Relation:_____

Responsible Party Information (If someone other than yourself is responsible for payment):

Name:_____
FIRST MI LAST

Home Address:_____
NO & STREET APT No CITY STATE ZIP

Social Security #:_____ - _____ - _____ Home Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Medical Insurance Information: (Please provide us with information on all medical/health insurance coverages that you have. We also need to make a copy of your most recent insurance card to keep on file)

1) Insurance Company Name:_____

Address:_____

ID or Policy #: _____ Group#;_____

Phone: ( ) _____ Co-Payment $ _____ Prior Authorization Required? Yes ____ No ____

Name of Primary Insured (if other than self): _____ **DOB** _____

2) Insurance Company Name:_____

Address:_____

ID or Policy #: _____ Group#;_____

Phone: ( ) _____ Co-Payment $ _____ Prior Authorization Required? Yes ____ No ____

Name of Primary Insured (if other than self):_____

(Please Complete Other Side)

Name of Referring Doctor:_____

Address:_____
NO & STREET APT No CITY STATE ZIP

Name of Your Medical Doctor:_____

Address:_____
NO & STREET APT No CITY STATE ZIP

Name of Any Other Eye Doctor:_____

Address:_____
NO & STREET APT No CITY STATE ZIP

Signature On File Authorization

I request that payment of authorized Medicare or other Insurance payment be made to the Doctor on my behalf for any services furnished to me by my Physician. I authorize any holder of medical information about me to release to the Center For Medicare and Medicaid Services and its agent or any carrier any information needed to determine the benefits payable for related services.

Signature of Patient or Responsible Party: _____ Date:_____

I further understand that I am responsible for the entire bill for medical services provided even though insurance has been filed on my behalf. Insurance is filed as a courtesy to our patients. Balances are due within 30 days of filing date. Insurance co-payment and/or deductible are due at the time of service. Payment for non-covered services by private insurance is also due once services are rendered.

Signature of Patient or Responsible Party: _____ Date:_____

Please COMPLETE this form and give it to the Receptionist at the Front Desk or Mail to our office:

PRIVACY PRACTICES ACKNOWLEDGEMENT

TRI LAKE EYE CLINIC
302 Railroad Street
Water Valley, MS. 38965
(662) 473-2181

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ DOB_____

Signature_____

Date_____

FOR OFFICE USE ONLY

We attempted to optain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An Emergency situation prevented us from obtaining the acknowledgement
___ Other (Please Specify)

_____

_____

_____