Patient Registration Form

CLINTON OPHTHALMOLOGY

Patient Information

Patient Information				
Last Name:	First Name:	M.I.:	Previous Name (if applicable)	
Mailing Address:		Apt #		
City/State/Zip:			Work Related Visit? ❑ Yes ❑ No	
Home Phone:	Cell Phone:	Work Phone:		
Chose Clinic because/Referred to clinic by ☐ Family/Friend ☐ Doctor's Office ☐ Hospital ☐ Insurance Plan ☐ Other		Voicemail, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work		
Family Physician or Pediatrician:	Date of Birth:	Sex: ❑ Male ❑ Female		
Marital Status:	Social Security #:			
Employer Name:	Emergency Contact Name:			
Emergency Contact Phone #:	Relationship to Patient:			

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the **parent or guardian bringing the patient** in will be **listed** as the **guarantor**

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No

Standing Release of Personal Health Information: In most instances Clinton Ophthalmology cannot legally provide health information to anyone including family members without your written consent. This includes test results. Please list any individuals whom you authorize Clinton Ophthalmology to release your health information. This authorization will remain in effect until you rescind the authorization in writing. Please be sure to include first and last name as well as birth date and phone number so we can verify the individual's identity.

Name	Date of Birth	Phone:

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Vision Insurance (please select) ☐ None ☐ Davis Vision ☐ EyeMed ☐ VSP ☐ Other

I certify that I have read and agree to Clinton Ophthalmology, PC (COPC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to COPC all money to which I am entitled for medical expenses related to the services performed from time to time by COPC. I authorize COPC to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 60 days of notification of the amount due will result in submission to an outside collection agency and a $25.00 fee. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I authorize Brandy Cook, DO or designees to perform routine diagnostic procedures and medical treatment. I am aware there is a $25.00 fee for appointment no shows and cancellations with less than 24-hour notice.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to me or on my behalf to the rendering physician of COPC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. This request is effective until revoked by the beneficiary in writing. A photocopy of the authorization and assignment shall be considered as valid as the original

I have reviewed a copy of Clinton Ophthalmology, PC Privacy Notice. ☐ (Initials)

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____