Ozark Eye Center

PATIENT REGISTRATION

Account #_____ Doctor_____ Date_____

Mr.___ Mrs.___ Ms.___ Miss___

Full Name _____ Spouse's Name_____

Address_____

City, State_____Zip Code_____

Soc. Security #_____ Driver's License #_____ State_____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail address _____

Sex _____Male _____Female

Marital Status _____Single _____Married _____Divorced _____Widowed

Birthdate_____ Height_____ Weight_____

Have you been seen by one of our doctors in the past?_____

If yes, which doctor?_____Approximate Date_____

Who referred you to our practice? Please write name:_____

__Medical Doctor ___Optometrist ___Friend ___Relative ___TV/Radio ___Yellow Pages ___Welcome Service ___Other

Employer's Name_____ Retired?_____

Address_____ Phone #_____

Spouse's Employer_____ Retired?_____

Address_____ Phone #_____

Were you injured at work?_____ If so, date of injury_____

Visit requested/approved by:_____, Company Representative

Nearest person living outside your home we can contact in case of an emergency_____

Relationship to patient _____

Address_____ Phone #_____

Legal Representative/Guardian Name_____

Address _____ Phone #_____

Family Physician_____

Name of your pharmacy_____ Phone #_____

Please complete insurance information on reverse side of this page.

IMPORTANT NOTICE

It is the ***patient's responsibility*** to obtain and provide any ***Referral Numbers,*** if required by your insurance company, prior to being seen by the doctor.

The patient is financially responsible for co-pay amounts, deductibles, co-insurance and any balance not paid by your insurance company; including any services deemed non-covered by your insurance company.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection.

Signature_____ Date_____

Primary Insurance Coverage

Company Name_____ Policy #_____

Group #_____ Subscriber_____ Relation_____

Policyholder's D.O.B._____ Employer_____

Secondary Insurance Coverage

Company Name_____ Policy #_____

Group #_____ Subscriber_____ Relation_____

Policyholder's D.O.B._____ Employer_____

Assignment of Medicare Benefits

I understand that the physicians of Ozark Eye Clinic are Medicare participating physicians and have agreed to accept assignment of my Medicare benefits. I hereby request payment of my authorized Medicare benefits to the physician who renders services to me. I likewise authorize payment of any supplemental "Medigap" benefits to the physician.

I further understand that because the physicians are participating, I am only responsible for payment of any unmet portion of my annual Medicare deductible, the 20% co-insurance portion of the approved Medicare allowance for each service, and for any services determined to be **non-covered** by the Medicare program, such as routine examinations, prescription drugs or contact lenses, and/or eyeglasses.

To the extent necessary to determine liability for payment and obtain reimbursement, I authorize disclosure of my medical record.

I have read, or had explained to me, and understand the contents of this authorization form.

Signature_____ Date_____ Medicare # _____

Assignment of Non-Medicare Insurance Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits, to which I am entitled, to the physician(s) of Ozark Eye Center who render services to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of my medical record.

Signature_____ Date_____