PATIENT REGISTRATION FORM -- WORCESTER EYE CONSULTANTS

Patient Name____ SS#_________________________

Mailing Address____ Date of Birth _________________

City_____________________________________ State___________________ Zip ___________________

☐ **Check here if you have another seasonal mailing address for part of the year and list address on back.**

Phone: Home _____________________Cell ______________________Work________________________

Gender: Male Female Primary care physician____

Who recommended Worcester Eye Consultants ____

Is this visit for a work related injury? Yes No If yes, please complete next line:

Employer + WC # ____

INSURANCE INFORMATION

- **Person Responsible for Payment**

Name____ SS#_________________________

Relationship to Patient_______________________________________ Date of birth _________________

Mailing Address____

City_____________________________________ State___________________ Zip Code______________

Phone: Home _____________________Cell ______________________Work________________________

- **Primary Insurance Company**

Insurance_____________________________ Group #_____________ Subscriber ID #_______________

Name of Insured____ Date of Birth_________________

Relationship to Patient____

- **Secondary Insurance Company**

Insurance_____________________________ Group #_____________ Subscriber ID #_______________

Name of Insured____ Date of Birth_________________

Relationship to Patient____

- **How will you pay today if you do not have insurance OR if we do not bill your insurance plan?**

( ) Cash ( ) Credit Card *(MC, Visa, Discover accepted)*

- **Insurance copayments and fees for non-covered services must always be paid on day of visit.**

ASSIGNMENT AND RELEASE

1) **I authorize this office to release any information necessary to process insurance claims.**
2) **I authorize my insurance benefits for this visit and future visits to be paid directly to the physician.**
3) **I understand that I am financially responsible for all non-covered services.**
4) **It is my obligation to call my primary care physician to obtain a referral when necessary for this and future visits. If I do not obtain a referral when one is needed, I will be responsible for payment for services rendered.**
5) **I am responsible to inform this office of any changes in my insurance on all visits and to know which services and providers are covered under my insurance plan or I will be responsible for payment for services received.**

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Signature of Patient or Person Financially Responsible **Date**