

**Eye Care Center of Lake County
Patient Registration Form**

Patient's First Name _____ Middle Initial _____ Patient's Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Social Security # _____ Date of Birth _____ Marital Status _____

Emergency Contact _____ Relationship _____

Emergency Phone Number _____

Employer Name _____ Employer Address _____

Employer Phone Number _____

Spouse's Name (If applicable) _____ Spouse's Employer Name _____

Spouse's Employers Address _____ Spouse's Employers Phone Number _____

Parent's Name (If age 17 or under) _____ Parent's Employer Name _____

Parent's Employer Address _____ Parent's Employer Telephone Number _____

Primary Insurance Company Name _____

Member's Name _____ Member's Date Of Birth _____ Member's Relationship to Patient _____

Member's ID # _____ Member's SS # _____ Member's Group # _____

Secondary Insurance Company Name _____

Member's Name _____ Member's Date Of Birth _____ Member's Relationship to Patient _____

Member's ID # _____ Member's SS # _____ Member's Group # _____

Name of Family Doctor or Primary Doctor _____

Telephone Number of Doctor _____

How did you hear of the Eye Care Center?

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be paid to The Eye Care Center of Lake County on my behalf for any services furnished me by any physicians of that clinic. I authorize any holder of information about me to release to the Health Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for payment of Medicare's deductible (if any), co-insurance (if applicable) and non-covered services

PAYMENT AGREEMENT:

I agree to be responsible for full payment of all charges (office visits, examinations, tests, surgery and eyeglasses) regardless of amount paid by any insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named physicians to release any information acquired in the course of my examination or treatment to my insurance company.

Patient Name
(Please Print) _____

Guardian Name
(If age 17 or under) _____

Patient
Signature _____

Guardian
Signature _____

Date _____