Sound Eye and Laser, P.S.

Stephen G. Phillips, M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Please Print and Answer all Questions

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Patient Name: ____ ☐ Female ☐ Male
(Full Legal Name) Last First Middle

Birth Date: ______ / ______ / ________ Age: ______ Social Security Number: ______ - _____ - _______

Patient Home Address: ____ Apt. #: ______

City: ______________________________ State: ________ Zip Code: ____________

Primary Phone: (_____) ______-________ Secondary Phone: (_____) ______-________

Emergency Contact:____________________ Relationship:____________ (_____) ______-________

E-mail: ______________________________@____________

Patient's Employer: ______________________________ **Occupation:** ____________________

Work Phone: (_____) ______-________

Primary Care Physician: ______________________________ Phone: (_____) ______-________

WHOM MAY WE THANK FOR REFERRING YOU?

Name: ______________________________ May we contact this person? ☐ Yes ☐ No

VISION AND HEALTH INSURANCE

Please notify your receptionist if this is an L&I or MVA claim

Do you have vision insurance separate from your Medical Insurance? ☐ Yes ☐ No

Vision Insurance: ______________________________ Effective Date: _____/_____/_____

Policy # ____________ Group # ____________ Employer or Group Name ____________

Subscriber's Name: ____________________ Birth Date _____/_____/_____ Relation to Patient: ____________

Primary Medical Insurance: ______________________________ Effective Date: _____/_____/_____

Policy # ____________ Group # ____________ Employer or Group Name ____________

Subscriber's Name: ____________________ Birth Date _____/_____/_____ Relation to Patient: ____________

Secondary Medical Insurance: ______________________________ Effective Date: _____/_____/_____

Policy # ____________ Group # ____________ Employer or Group Name ____________

Subscriber's Name: ____________________ Birth Date _____/_____/_____ Relation to Patient: ____________

IS THIS PATIENT A MINOR? ☐ Yes ☐ No If Yes, please fill out Responsible Party Information:

Person Responsible for Bill: ______________________________ Birth Date: _____/_____/_____

Home Address: ☐ Same as above ______________________________ Apt. # ________

City: ______________________________ State: ________ Zip Code: ____________

ASSIGNMENT AND RELEASE

I authorize treatment of the patient named above. I attest all information supplied on this form is complete and accurate. I agree to pay all fees and copayments for services not covered by a contracted medical plan, including services not covered due to incomplete or inaccurate information supplied by me; payments will not be delayed or withheld due to any insurance coverage or pendency of claims thereon; all proceeds of insurance are assigned to Sound Eye and Laser, P.S. where applicable but without their assuming responsibility for the collection thereof. All charges are the responsibility of the undersigned, due and payable within thirty (30) days of the statement closing date. Balances aged ninety (90) or more days may accrue a 1% rebilling fee per month (minimum $1.00). A copy of this assignment is as valid as the original. A copy of the HIPAA Notice of Privacy Practices is available upon request.

Patient Signature: ______________________________ Date: ______/______/______

For office use only:

SEAL Verification of Information ________ **Copies or Cards** ________ **Form Complete** ________

Re-verified Date _____/_____/_____ **Re-verified Date** _____/_____/_____ **Re-verified Date** _____/_____/_____