PATIENT REGISTRATION FORM

IDAHO EYE AND LASER CENTER

PATIENT INFORMATION

Today's Date:		Chart#:	
Patient Name:		Birthdate:	Age:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	EMAIL:	
Marital Status:	Gender:	Social Security #:	

Race (Circle One): American Indian/Alaska Native Black/African American White Asian Pacific Islander/Hawaiian Decline to specify

Ethnicity (Circle One): Hispanic/Latino Not Hispanic/Latino Decline to specify

Language (Circle One): English Spanish French Other: _____

Employer:	Employer phone #:
Primary Care Physician:	Pharmacy:

INSURANCE INFORMATION

Responsible Party Name:	Birthdate:	Home Phone:

Primary Insurance:	Policy #:	Group #:
Patient relationship to subscriber:		
Secondary Insurance:	Policy #:	Group #:
Patient relationship to subscriber:		

IN CASE OF EMERGENCY: In my absence, I authorize the Idaho Eye Center to report my medical information to my Emergency Contact and/or the following person (s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE ASSIGNMENT AND RELEASE OF RECORDS: I hereby authorize the Idaho Eye and Laser Center, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to any person or entity responsible for payment for the medical services rendered to me at the facility, including third party payors, self-insurers, worker's compensation carriers and government agencies. I also release information to any health professionals involved in my care for the purpose of facilitating the continuity of my medical care. I acknowledge that this authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Idaho Eye and Laser Center. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid by my insurance plan, Medicare, health service plan or health maintenance organization. Idaho Eye and Laser Center may not participate with your health care coverage plan and their charges may not be covered. By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason. A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

Signature: _____ **Date:** _____