Registration : **1960 Eye Surgeons, P.A.**

Date	Account ID (office use only)	Chart ID (office use only)	Other ID (office use only)

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age

Address: Home number:
Cell number:
Work number:
Email:
Pharmacy Name: Pharmacy Number:
Emergency Contact:

Provider	Family Physician	Referring Physician

HIPAA Approved Contacts

Last Name	First Name	Middle	Gender	Birthdate	Relationship to patient

Home Number:	Cell number:	Work Number:

Last Name	First Name	Middle	Gender	Birthdate	Relationship to patient

Home Number:	Cell number:	Work Number:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to 1960 Eye Surgeons, P.A. , all medical benefits, if any, otherwise payable to me for secures rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating obtaining payment for services rendered to me, and conducting healthcare operations.

Signature:	Date: