

Holland Eye Center, P.C.
Patient Registration Information

Please **PRINT AND** complete **ALL** sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY'S INFORMATION

Relationship to Patient: Self Spouse Child Other: _____

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance card(s) & picture ID to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse

Policy #: _____ Group #: _____ Copay: \$ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse

Policy #: _____ Group #: _____ Copay: \$ _____

WHO REFERRED YOU TO OUR PRACTICE?

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits • Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Holland Eye Center, P.C., and any assisting physicians for services rendered until I revoke this authorization in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature or Authorized Person: _____

If Not Patient, Relationship to Patient: _____