Maple Eyecare

Patient Registration (please print) Date:

Patient_____
Last Name First Name Initial

Responsible Party *(if a minor)*_____

Street Address_____

City_____ State_____ Zip_____

Sex __ M __ F Birthdate _____ E-mail _____

__ Single __ Married __Widowed __ Divorced

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse *(or responsible party)* Name_____ Birthdate_____

Business Name and Address_____

Occupation_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse's Social Security #_____

Do you have Vision Insurance (coverage for routine eye exams/glasses/contacts)? __No __ Yes

If Yes, name of Insurer_____

Do you have Medical Insurance? __ No __ Yes (please fill out below)

Name of Primary Insurer_____

Name of Policy Holder _____Group #_____ Subscriber #_____

Name of Secondary Insurer (if any)_____

Name of Policy Holder _____Group #_____ Subscriber #_____

In case of emergency, who should be notified?_____ Phone_____

How did you learn of our practice (name if patient, doctor, Ins co)_____

May we use your name in thanking this person? __Yes __No

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (name of insurance company)_____
And assign directly to Dr._____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all 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.

Signature of Insured/Guardian _____ Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____ Date_____