MARYLAND EYE
CONSULTANTS & SURGEONS

Patient Registration Form

Date:

PATIENT INFORMATION:

Patient's Legal Name *(**Last**, First, Middle)*			
Social Security Number	Date of Birth	Sex M F	Marital Status D S M W
Primary Care Physician			Home Phone Number
Patient Street Address *(Required)*			Cell Phone Number
City	State	Zip	E-Mail Address
Occupation			Employer

INSURANCE INFORMATION:

Name of Primary Insurance		Name of Secondary Insurance	
Member/Policyholder Name		Member/Policyholder Name	
Member ID#	Date of Birth	Member ID#	Date of Birth
Insurance Co. Phone Number	Group #	Insurance Co. Phone Number	Group #

EMERGENCY CONTACT:

Name *(**Last**, First, Middle)*			Home Phone Number	
Street Address *(Required)*			P.O. Box *(if applicable)*	
City	State	Zip	Work Phone Number	Extension
Relationship Child Spouse Other			Cell Phone Number	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize billing services rendered by Maryland Eye Consultants and Surgeons. Payment from my insurance carrier(s) should be made directly to Maryland Eye Consultants and Surgeons. I also agree to be held financially responsible for any services not covered by my insurance carrier(s). I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my health insurance plan in order to determine benefits which I may be entitled. (Or in case of part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

Signature Date