MARYLAND EYE
CONSULTANTS & SURGEONS

Patient Registration Form

Date:

PATIENT INFORMATION:

Patient's Legal Name *(**Last**, First, Middle)*

Social Security Number (Last 4 Numbers)	Date of Birth		Sex M F
Primary Care Physician			Home Phone Number
Patient Street Address *(Required)*			Cell Phone Number
City	State	Zip	E-Mail Address
Occupation			Employer

Race:

American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander

White Do Not Know/Decline

Ethnicity:

Hispanic/Latino Not Hispanic/Latino Don't Know/Decline

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 for services rendered by any of the above doctors. 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 to. (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