Boston Eye Care Consultants
Robert A. Lytle, MD

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient:
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth:, Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed _____ **Date:** _____