Welcome to Simpson Eye Associates, LTD
Patient Registration

simpson eye

Patient Information (Please Print)

Todays Date

PATIENT NAME (LAST, FIRST, MIDDLE)	PATIENT DATE OF BIRTH	GENDER (Optional)
		☐ MALE ☐ FEMALE ☐ OTHER

ADDRESS	UNIT	CITY, STATE, ZIP CODE

MOBILE (CELL)	CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION?	OTHER PHONE	CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION?
	YES NO		YES NO

EMAIL ADDRESS	MARITAL STATUS

PREFERRED LANGUAGE	RACE (Optional)	ETHNICITY (Optional)

Account Guarantor if not the patient

GUARANTOR OF ACCOUNT (FINANCIALLY RESPONSIBLE PARTY)

NAME: _____ ADDRESS: _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE : _____

Primary and Secondary Insurance with Subscriber info

	Primary Insurance	Secondary Insurance
Insurance Name Insurance		
Address Insurance		
City/State/Zip		
Group Number		
Policy Number		
Effective Date		
Subscriber's Name		
Subscriber's Date of Birth		
Relationship to Patient		

Emergency Contact

EMERGANCY CONTACT NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT

CELL PHONE NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER

I authorize Simpson Eye Associates, LTD to disclose my Patient Health Information to the following person(s)

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

Primary Care Physician

PRIMARY CARE PHYSICIAN NAME:	PRIMARY CARE PHYSICIAN PHONE :

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Simpson Eye Associates, LTD to release any medical or incidental information that may be necessary for either medical care, or to submit a health insurance claim, in processing applications for financial benefit, or for quality assurance.

APPLICABLE TO MEDICARE PATIENTS:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

GUARANTEE OF PAYMENT:

In consideration of all medical services given by Simpson Eye Associates, LTD to the patient named above, I agree to pay Simpson Eye Associates, LTD all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due within **30** days of billing date. A late charge may be added to the account for charges not paid within **90** days.

SERVICE CHARGE: A $25 SERVICE CHARGE PER RETURNED CHECK WILL BE ASSESSED

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand that it is my responsibility to notify Simpson Eye Associates, LTD of any changes to the above information.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ DATE: _____

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY: _____