Pt. #________________________________
(for office use only)

CHESTER COUNTY EYE CARE ASSOCIATES, P.C.

Welcome To Our Practice

PATIENT REGISTRATION: Date:______________________________

Please **PRINT** All Information

Mr. Ms. Mrs. Miss Dr. Jr.

LAST Name of **Patient**:________________________ FIRST Name of **Patient**:________________________ M.I.______

Social Security # of **Patient**:____________________________ E-Mail Address:____________________________________

Street Address:________________________________ City:____________________ State:________ Zip:__________

Home Phone #:______________________ Work Phone #:______________________ Date of Birth:_____/_____/_____

Sex (circle): M F Married:_____ Single:_____ Widowed:_____ Divorced:_____ Race:__________________________

PERSON RESPONSIBLE FOR PAYMENT (If Patient is a Minor: Parent or Guardian)

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

Name:____________________________ Relationship:______________ D.O.B.____________ S.S.#__________________

Address:______________________________________ City:______________________ State:________ Zip:__________

Employer:____ Occupation:____________________________________

Employer's Address:________________________________ City:__________________ State:________ Zip:__________

Home Phone #:______________________ Work Phone #:______________________

Patient's Occupation:____ Student:_____ full time:_____ part time:_____

School Name____________________________________

Employer:____

Employer's Address:________________________________ City:__________________ State:________ Zip:__________

Is condition work-related? Yes:_____ No:_____ Date of Accident:____

PRIMARY (1st) INSURANCE INFORMATION: (We would like to make a photocopy of your card.)

Name of Insurance Company:____

Subscriber's Name:____ S.S.#__________________

Patient's Relationship to the Insured (check one): Self:__________ Spouse:__________ Child:__________ Other:__________

Subscriber's Employer:____ Subscriber's Date of Birth:_____/_____/_____

ID or Policy #:____________________________________ Group #/Plan #:____________________________________

SECONDARY (2nd) INSURANCE INFORMATION: (We would like to make a photocopy of your card.)

Name of Insurance Company:____

Subscriber's Name:____ S.S.#__________________

Patient's Relationship to the Insured (check one): Self:__________ Spouse:__________ Child:__________ Other:__________

Subscriber's Employer:____ Subscriber's Date of Birth:_____/_____/_____

ID or Policy #:____________________________________ Group #/Plan #:____________________________________

PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

REFERRAL & PHARMACY INFORMATION:

Who referred you to our office (examples: family doctor, optometrist, friend, saw ad)?______________________________

Family Physician:__________________ Address:______________________ Phone #:______________

Local Pharmacy Name & Town:____________________ Phone #:_____________ Fax #:_____________

Mail Order Pharmacy Name:______________________ Phone #:_____________ Fax #:_____________

IN CASE OF EMERGENCY, the following person should be notified (Family member or friend not living at your residence)

Name:____ Relationship:__________________

Address:____ Phone:______________________

INSURANCE INFORMATION

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to **Chester County Eye Care Associates, P.C.** for any services furnished to me by the physicians. I understand that I am financially responsible for payment of any services or supplies that are deemed not medically necessary or non-covered by my insurance company. This includes refractions, contact lens examinations, and supplies. It is my responsibility to notify this office of any change in my insurance plan before my visit. I further understand that I am responsible for charges incurred when my insurance coverage has been changed or terminated. I also authorize to release to my insurance company any information required to process claims of benefits.

____ ______________________

Patient (or Responsible Party) Signature Date

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized **MEDICARE** benefits be made either to me or on my behalf to **Chester County Eye Care Associates, P.C.** for any services furnished me by the physicians. 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 payable for related services.

____ ______________________

Patient (or Responsible Party) Signature Date

MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I request that payment of authorized **MEDIGAP** or **SUPPLEMENTAL** benefits be made either to me or on my behalf to **Chester County Eye Care Associates, P.C.** for any services furnished me by the physicians. I also authorize any holder of medical information about me to release to the (Medigap insurer or name of supplemental insurer) any information needed to determine these benefits payable for related services.

____ ______________________

Patient (or Responsible Party) Signature Date