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SIERRA EYE CARE

Patient Registration

Name last first middle

Date of Birth Age Social Security # Gender: M F

Address City State Zip

Home Phone () Work Phone ()

Marital Status: S M D W Spouse's name

Occupation Employer

Emergency Contact Relationship Phone ()

Responsible Party if Patient is a Minor

Relationship Date of Birth SS#

Medical Information

Reason for exam

Referred by Doctor/Hospital Friend/Family Newspaper Telephone Directory Internet Other

Primary Care Physician

Address street city state zip Phone ()

Medical Insurance Information

Primary Insurance Coverage

Secondary Insurance Coverage

Insurance Name

Insurance Name

Group/Policy #

Group/Policy #

Subscriber Name

Subscriber Name

Relationship to Patient

Relationship to Patient

Subscriber's DOB

Subscriber's DOB

Subscriber's SSN

Subscriber's SSN

Vision Insurance Information

Primary Insurance Coverage

Secondary Insurance Coverage

Insurance Name _____

Insurance Name _____

Group/Policy # _____

Group/Policy # _____

Subscriber Name _____

Subscriber Name _____

Relationship to Patient _____

Relationship to Patient _____

Subscriber's DOB _____

Subscriber's DOB _____

Subscriber's SSN _____

Subscriber's SSN _____

Please note it is your responsibility as a patient to know your insurance benefits. Should you have any questions regarding covered benefits, please call your insurance company. If you are insured by an insurance that requires a referral from your primary care physician, it is your responsibility to obtain that prior to your visit. Please provide the referral or authorization at the time of your initial visit to avoid cancellation and rescheduling of your appointment. To avoid any additional service charges, please note that all insurance co-payments are due at time of appointment.

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance to pay directly to Colin Arnold, MD insurance benefits otherwise payable to me. I authorize Dr. Arnold to release all information necessary to secure the payment of my benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all claims. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient (Guardian if Minor)

Date