



PEDIATRIC OPHTHALMOLOGY of Erie

ADULT PATIENT REGISTRATION

Name: _____ Age: _____ Birth Date: __/__/____ Sex: M F

Address: _____ City: _____ State: ____ Zip: _____

Telephone: (Home) _____ (Cell) _____

Employer: _____ Work Phone: _____

Patient's Social Security Number: _____ Spouse's Name: _____

Primary Care Doctor: _____ Were you referred by this doctor? Y N

In case of emergency notify: _____ Relationship: _____

Phone Number: _____

INSURANCE COVERAGE INFORMATION

Primary Insurance Information:

Name of Insurance: _____

Employer _____

Employee's Name _____

Employee's Date of Birth _____

I.D. Number _____

Group Number _____

Secondary Insurance Information

Name of Insurance _____

Employer _____

Employee's Name _____

Employee's Date of Birth _____

I.D. Number _____

Group Number _____

PLEASE GIVE "ALL" CURRENT INSURANCE CARDS TO RECEPTIONIST FOR COPYING PURPOSES

I hereby authorize and direct payment of Pediatric Ophthalmology of Erie, Inc. for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance. A copy of this authorization may be used in place of the original. This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered whether or not payable by said insurance. In the event payment is not made and the account is referred to a collection agency or attorney, I will pay the costs of collection including attorney's fees and costs incurred.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received/been offered a copy of this office's Notice of Privacy Practices.

(Please print name)

SIGNATURE _____ DATE _____

HOW WILL TODAY'S VISIT/COPAY BE PAID?

CASH _____ CHECK _____ VISA/MC/DISCOVER _____