Willcockson Eye Associates, P.C. **Chart #** ___________________

Patient Registration

PATIENT INFORMATION

____ ____ / ____ / ____ Male

Last First Middle Date of birth Female

Marital Status: Single / Divorced / Separated / Married / Widowed (Circle one) (Circle one)

____ _____________________________

Street / PO Box City State Zip Code

Home Phone (____)______________ Cell Phone (____)______________

Social Security Number _______-_____-_________

Have you or any member of your immediate family been a patient at this clinic? Yes / No

If yes, please list full names: ____

PATIENT'S EMPLOYMENT (If applicable)

____ (______)_______________

Employer Employer's Phone Number

SPOUSE (If applicable)

Name ____ _____ / _____ / _____

Last First Middle Date of birth

____ (______)_______________

Employer Employer's Phone Number

If the patient is a child please list the father and mother here. If the parents are divorced or separated please indicate the custodial parent here. ☐ **Father** ☐ **Mother** The billing will go to the custodial parent.

Father ____ _____ / _____ / _____

Last First Middle Date of birth

____ _____________________________

Street / PO Box City State Zip Code

(____)____________________ _________________________ (______)_______________

Phone Number Employer Employer's Phone Number

Mother ____ _____ / _____ / _____

Last First Middle Date of birth

____ _____________________________

Street / PO Box City State Zip Code

(____)____________________ _________________________ (______)_______________

Phone Number Employer Employer's Phone Number

BILLING INFORMATION (We prefer one billing name per family.)

(Only complete this section if information is different than patient / parent information above.)

Billing Name ____ _____ / _____ / _____

Spouse / parent / guardian / POA Date of birth

Address ____ Phone (____) ______________

ADULT RELATIVE OR FRIEND (NOT living in the same household as patient)

Name ____ (____)____________

Last First Middle Phone number with area code

Referral If you were referred here by a doctor please list his / her name here ______________

Revised 11/05-14a – V14

(Over Please)

INSURANCE INFORMATION

Primary Medical Coverage (Insurance, Medicare, Medicaid/Welfare)

Company name ____________________________ Policyholder/Insured party ______________
Address ___________________________________ Policyholder birth date (if not pt.)________
___________________________________ Group # _________________
___________________________________ ID # _________________
Phone number (______) _____________________ Payer ID# _________________
Social Security # of the insured if the patient is not the policyholder. _______-_____-_________

Secondary/Supplement Medical Coverage (if applicable)

Company name ____________________________ Policyholder/Insured party ______________
Address ___________________________________ Policyholder birth date (if not pt.)_________
___________________________________ Group # _________________
___________________________________ ID # _________________
Phone number (______) _____________________ Payer ID# _________________
Social Security # of the insured if the patient is not the policyholder. _______-_____-_________

Third Insurance (if applicable)

Company name ____________________________ Policyholder/Insured party ______________
Address ___________________________________ Policyholder birth date (if not pt.)________
___________________________________ Group # _________________
___________________________________ ID # _________________
Phone number (______) _____________________ Payer ID# _________________
Social Security # of the insured if the patient is not the policyholder. _______-_____-_________

Do any of your insurance companies require preauthorization certification? Yes / No
Phone number (_____) ________________

Acknowledgment and Release

The Clinic holds the patient fully responsible for payment for all services. The Clinic will file claims to your insurance company if you provide us with the complete and accurate information necessary. I hereby authorize Willcockson Eye Associates, P.C. to release any information acquired in the course of my examination or treatment to my insurance company or third party payors I may designate. Further I authorize payment directly to the Clinic. I understand I am financially responsible to the Clinic for charges not covered by this authorization.

x ____ Date _______________
Patient or parent/guardian signature

All Medicare patients must read and sign:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Willcockson Eye Associates, P.C. for any services furnished me by that physician or supplier. 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 to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

x ____ Date _______________
Patient or parent/guardian signature