REGISTRATION

(PLEASE PRINT)

Phone (973) 427-7801
Fax (973) 427-7969
highmountaineye@aol.com

Home Phone_________________ Date_____________

Patient____
Last Name First Name Initial

Responsible Party *(if a minor)*____

Street Address____

City____ State___________________ Zip__________

Sex __ M __ F Birthdate _______________ E-mail _____________________________________

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed By____

Business Address____

Occupation_________________________________ Business Phone_________________________

Spouse *(or responsible party)* Name_________________________________ Birthdate___________________

Business Name and Address____

Occupation__________________________________ Business Phone_________________________

Who is responsible for this account?___________________________ Relationship to Patient______________

Social Security #______________________________ Spouse's Social Security #_______________________

Do you have Vision Insurance (coverage for routine eye exams/glasses/contacts)? ☐ No ☐ Yes

If Yes, name of Insurer____

Do you have Medical Insurance? ☐ No ☐ Yes (please fill out below)

Name of Primary Insurer____

Name of Policy Holder _______________________Group #__________________ Subscriber #_____________

Name of Secondary Insurer (if any)____

Name of Policy Holder _______________________Group #__________________ Subscriber #_____________

In case of emergency, who should be notified?___________________________ Phone____________________

How did you learn of our practice (name if patient, doctor, Ins co)______________________________________

May we use your name in thanking this person? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (name of insurance company)____
And assign directly to Dr.____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian ____ Date_________________________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ____ for any services furnished me by that physician. 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 or the benefits payable for 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" is indicated in item 9 of the HCFA-1500 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature____ Date______________________