Registration

Date	Account ID	Chart ID	Other Id	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone Other	How did you hear of us?
Address 2	Email:	

City	State	Zip	Employer Name & Address	Occupation

Emergency Contact Phone	Pharmacy Name & Address	Pharmacy Phone

Pref Language	Race:	Ethnicity:	

Provider	Family Physician	Referring Physician

Medical Insurance	Policyholder	Relationship	Copay	Policy ID	Group ID
1					
2					
3					

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

Is this auto related? Yes / No **Is this work related? Yes / No**

Patient's or Authorized Person's Signature

I, the undersigned, give my authorization to treat and assign directly to Koziol-Thoms Eye Associates, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered 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. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date:
X	

Please attach all pertinent insurance ID cards for photocopying