

## Mountain Empire Eye Physicians Patient Registration

<b>Patient Name</b>			<b>Salutation</b>	
<b>Date of Birth</b>		<b>Age</b>		
<b>Sex</b>			<b>SS #</b>	
<b>Address</b>				
			<b>Country</b>	UNITED STATES

### Patient Communication

<b>Preference:</b>	Phone - Work			
	<b>Pharmacy Name:</b>		<b>Street/City/Zip:</b>	
<b>Home Phone #</b>		<b>Work Phone #</b>		<b>Extension</b>
<b>Cell Phone #</b>		<b>Email</b>		

### Information

<b>Marital Status</b>		<b>Primary Care Doctor (first and last name)</b>	
<b>Who referred you?</b>		<b>Endocrinologist (first and last name)</b>	
<b>Occupation</b>		<b>Employer</b>	

### Account Responsible

<b>Responsible</b>		<b>Date of Birth</b>	
<b>Relationship</b>		<b>SS #</b>	
<b>Address</b>			
<b>Home Phone #</b>		<b>Work Phone #</b>	<b>Extension</b>
<b>Email</b>			
<b>Insurance Balance</b>		<b>Total Balance</b>	
<b>Last Payment</b>		<b>Last Statement</b>	

### Primary Insurance

<b>Name</b>		<b>Group Name</b>	
<b>ID #</b>		<b>Group #</b>	
<b>Address</b>			
<b>Phone</b>		<b>PAY %</b>	
<b>Insured</b>		<b>Date of Birth</b>	
<b>Copay</b>			

### Secondary Insurance

<b>Name</b>		<b>Group Name</b>	
<b>ID #</b>		<b>Group #</b>	
<b>Address</b>			

Secondary Insurance			
Phone		PAY %	
Insured		Date of Birth	

Emergency Contact										
Sal	First	Middle	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

Release Of Medical Information - Status		
Name	Relation	Release Status

I authorize and request examination by the physicians and staff of including optometrists and ophthalmic technicians. I authorize the performance of whatever procedures the judgment of the above-named staff may deem necessary during treatment. I also authorize the administration of any anesthetics and analgesics, including eye drops, which the above staff deem advisable. I may request that any procedure not be performed. I authorize payment directly to of the insurance benefits otherwise payable to me for their services. I also authorize them to provide information to my insurance company directly pertaining to relevant claims. I understand that I may be charged and I agree to pay a fee for forms completion, medical records, collection agency or attorneys' fees pertaining to my account. By my signature below, I acknowledge that I have received the Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Parent or Legal Representative: \_\_\_\_\_ DATE: \_\_\_\_\_