Norton Eye Care PLLC

Registration Form

INTAKE DATE:____________________ COMPLETED BY:_________________________

REFERRING PHYSICIAN:_________________________

PATIENT NAME:__________________________________ **DATE OF BIRTH:**______________________

ADDRESS:___________________________CITY:__________________STATE________ZIP:__________

SS#________________________EMPLOYER:____

PHONE:_____________________WORK:___________________CELL:_______________________

SEX: FEMALE MALE MARITAL STATUS: SINGLE MARRIED DIVORCED

RESPONSIBLE PARTY:______________________________________SS#_________________________

ADDRESS:___________________________CITY:__________________STATE:_______ZIP:__________

PHONE:_____________________CELL:______________________DATE OF BIRTH_______________

INSURANCE #1:____

POLICY NUMBER:___________________________________GROUP NUMBER:_________________

POLICY HOLDER:__________________________PHONE:_________________CELL:_______________

INSURED'S DATE OF BIRTH:____________________SS#___________________________

INSURANCE #2:____

POLICY NUMBER:___________________________________GROUP NUMBER:_________________

POLICY HOLDER:_________________________PHONE:__________________CELL:_______________

INSURED'S DATE OF BIRTH:____________________SS#_____________________________

EMERGENCY CONTACT INFORMATION

NAME:____________________________________RELATIONSHIP:__________________________

HOME PHONE:____________________WORK:____________________CELL:______________________

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OUR BILLING COMPANY FOR PAPER AND ELECTRONIC BILLING TO YOUR INSURANCE COMPANY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL SERVICE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE NORTON EYE CARE PLLC'S BILLING COMPANY TO FILE FOR BENEFITS ON MY BEHALF FOR MEDICAL SERVICES RENDERED. INSURANCE PAYMENTS SHALL BE MADE DIRECTLY TO NORTON EYE CARE PLLC. IF I HAVE MEDICARE INSURANCE, I AUTHORIZE NORTON EYE CARE PLLC TO RELEASE TO THE SOCIAL SECURITY AND CARE FINANCING ADMINISTRATON OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES NOT PAID BY INSURANCE. THIS AUTHORIZATION IS VALID INDEFINITELY UNTIL REVOKED BY MYSELF OR BY NORTON EYE CARE PLLC.

SIGNATURE____DATE_____________________