LAKE SHORE RETINA, SC CORP

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:_____ **Email:**_____

First Name: _____ **Last Name:**_____

Date of Birth: _____ **Social Security Number**: _____

Gender: [ ]M [ ]F **Marital Status**: [ ]Single [ ]Married [ ]Widowed [ ]Separated [ ]Divorced

Home or Cell (Preferred Phone): _____**Work Phone**: _____

Mailing Address/ Street: _____

City: _____ **State**: _____ **Zip Code**: _____

Occupation: _____ **Employer**: _____

Employer's Address:_____ **Phone:**_____

Primary Insurance Company: _____

Policy #:_____ **Group #**_____

Secondary Insurance Company: _____

Policy #:_____ **Group #**_____

Subscriber Name (if not the patient): _____**Relationship to patient:** _____

Subscriber Birth date:_____**Subscriber ID#**_____**Group Number:**_____

Primary Care Physician Name (Medical Doctor): _____

Medical Doctor's Address: _____

Medical Doctor's Phone number: _____ **Fax Number**: _____

Patient referred to this office by: _____

Emergency Contact Name: _____ **Relationship:**_____

Emergency Contact Phone: _____

I hereby authorize Lake Shore Retina, SC Corp to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize Lake Shore Retina, SC Corp to release any information required in the course of my examination or treatment. I hereby assign to Lake Shore Retina, SC Corp, where applicable, all payment of medical services, all insurance 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. For medical care not covered by my insurance, including co-pays and deductibles, I agree to pay these at the time of the visit. I agree that it is my responsibility to bring any required referrals or authorizations for treatment at the time of or prior to the visit. A copy of this authorization shall be as valid as the original.

Patient Signature: _____ Date: _____