ALL CITY OPHTHALMOLOGY SERVICES, P.C.

PATIENT REGISTRATION FORM **Date**____________________

Patient Information (To be filled out by the patient)

Patient's Name:____ Sex: M ☐ F ☐ Date of Birth: __________
Last First M.I.

Current Address: ____ Apt. : ____________________

City: ____________________________ State: ______ Zip Code: __________ S.S.#: ______-______-________

Telephone (rank in order of preference): 1. ______________________ Home ☐ Work ☐ Cell ☐

2. ______________________ Home ☐ Work ☐ Cell ☐

3. ______________________ Home ☐ Work ☐ Cell ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Occupation:__________________________ Employer: ____

Employer's Address: ____

Who referred you to our office?

Name: ____ Telephone (if doctor): _________________________

Address (if doctor): ________________________________ City: _________________ State:____ Zip: _________

Who is your primary care physician?

Name: ____ Telephone: __________________________________

Address: ____ City: _________________ State: ____ Zip: _________

Insurance Information

Primary Insurance Company:

____

Address: _____________________________________

City:____________________ State: ____ Zip: ________

Insured's Name: _______________________________

Insured's Birthdate: _______________

ID #: __________________ Group #: _______________

Secondary Insurance Company:

____

Address: _____________________________________

City: ____________________ State: ____ Zip: ________

Insured's Name: _______________________________

Insured's Birthdate: __________________

ID #: ____________________ Group #: _____________

Emergency Contact Information

Emergency Contact Name: ____ Telephone: ______________________

Relationship to patient: ______________________________

I hereby certify that the information given by me above is true and correct.

Signature: X ____ **Date:** ________________________________

TURN OVER→

Insurance Authorization and Assignment

Name of Policy Holder____ **HIC Number**______________________

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to _______________________ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgement of Receipt of Privacy Notice – I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice;____

____

Signature: X ____ **Date:** ____________________

Statement of Patient's Financial Liability

I understand that I am personally financially responsible for charges incurred for services rendered by Dr. Crapotta, Dr. Dayan, Dr. Weseley and ALL CITY OPHTHALMOLOGY SERVICES if any of the following apply:

My health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services from Dr. Crapotta, Dr. Dayan, Dr. Weseley, and ALL CITY OPHTHALMOLOGY SERVICES and I have not obtained such an authorization or referral, or

I receive services in excess of such authorization or referral, or

My health plan determines that the services that I receive are not medically necessary, or

My health plan coverage has lapsed or expired at the time I receive services, or

I have chosen not to use my health plan coverage.

I also understand that I am responsible for all co-payments and co-insurance sums under my health plan.

Signature: X ____ **Date:** ____________________

ALL CITY OPHTHALMOLOGY SERVICES, P.C.

Patient's Name: ________________________________ **DOB:** ______________

Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) __ Yes __ No	
Please select the racial category or categories with which you most closely identify by placing an **"X"** in the appropriate box. Check as many as apply.	
RACIAL CATEGORY (Check as many as apply)	**DEFINITION OF CATEGORY**
__ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
__ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
__ Black or African American	A person having origins in any of the black racial groups of Africa.
__ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
__ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

PREFERRED LANGUAGE: ________________________________

Pharmacy Name: ________________________________

Pharmacy Address: ________________________________

Pharmacy Phone #: ________________________________

Signature: X ________________________________ **Date:** ___/___/____