Patient Registration Form

Name: First ______________________ MI __ Last _________________________ Date ________________
Sex (M or F) ______ Date of Birth (mm/dd/yyyy) ______________ Age ____ SSN ________________
Preferred name you go by (if applicable) _______________________

Contact Info:
Cell phone # _________________ Email _____________________ Preferred method of contact:
Home phone # ________________ ☐ same as cell phone ☐ Cell phone
Work phone # _________________ ☐ same as cell phone ☐ Home phone
☐ Work phone
Home Address ___________________________________ City ______________ State ___ Zip ________

Demographics:
Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employer _________________________________ Occupation ________________________
Primary Care Physician (PCP) ______________________________________ PCP location ____________
Referring Doctor: ☐ PCP ☐ Eye Doctor ____________________________ ☐ Other _________________
Pharmacy information ____

Financially Responsible Party (or Guarantor):
Patient's relationship to responsible party: ☐ Self ☐ Spouse ☐ Child ☐ Other
Complete the following if responsible party is different than the patient:
Name _________________________________ DOB ____________ Sex(M/F) ___ Phone ______________
Address (if different than patient's): ____
SSN ___________________ ____
Employer (name, city, state) ___________________________________ Employer phone _______________

Emergency Contact:
Name ____ Phone _______________________
Relationship to patient _______________________________
Address (if different than patient's) ____

Insurance Information:
Primary Insurance ____ Phone _______________________
ID # __________________________________ Group #/Name __________________________________
Relationship of Patient to Policy Holder/Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Complete the following if Policy Holder/Subscriber is different than the patient:
Name _________________________________ DOB ____________ Sex(M/F) ___ Phone ______________
Address (if different than patient's): ____
SSN ___________________ ____
Employer (name, city, state) ___________________________________ Employer phone _______________

Secondary Insurance ____ Phone _______________________
ID # __________________________________ Group #/Name __________________________________
Relationship of Patient to Secondary Ins Policy Holder/Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Complete the following if Policy Holder/Subscriber is different than the patient:
Name ________________________________ DOB ____________ Sex(M/F) ___ Phone ______________
Address (if different than patient's): ____
SSN ___________________ ____
Employer (name, city, state) __________________________________ Employer phone _______________

Acknowledgements, Authorizations, and Consents

Please read carefully and then sign below.

Receipt of Notice of Privacy Practices

➜ I have received a copy of the Eye Center of Grand Rapids Notice of Privacy Practices

Authorization To Release Health Condition/Information

➜ I give this practice permission to share or discuss my health information with the following people, while retaining the right to cancel this permission at any time in writing.

Name(s) ____ Relationship(s) _____________________

____ _____________________

Instructions For Accessing Patient Health Portal

➜ I have been given instructions on how to access the patient online portal, as summarized below.

✓Be able to send secure messages directly to your physician
✓Access basic health and appointment information

Online access is easy and secure, and it is available to any patient who supplies an email address. If you do not have an email address, you may either create one later and share it with us, or you may list an email address of someone else (such as a family member) whom you allow to gain access to your information. In order to sign up, you will need to enter an access code; this code can be requested from our office at any time.

Email address ________________________ Owner of email (if other than patient) ____________________

Financial Policy, Authorization, Assignment, and Responsibility of Account

➜ I have reviewed and accept the practice's **Financial Policy**. I hereby authorize that any insurance benefits of mine be paid directly to Eye Center of Grand Rapids, and I authorize the practice to release to my insurance companies and/or their intermediaries or carriers any medical information needed for claims reimbursement. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me, including any charges not covered or paid by my insurance. Should action become necessary to collect an unpaid balance, I agree to pay all reasonable legal fees, court costs, or other costs of collection.

Signature ________________________________ Date ____________