PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's Date _____ (Circle One)
Mr. Ms. Mrs.

Last Name _____ First Name _____ Middle _____ Other _____

Nickname _____ SSN: _____ Marital Status: _____ Gender: M F

Birthdate _____ Primary Language _____ Interpreter Needed? Y N

Street Address _____ PO Box _____ City, State & Zip _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Primary Care Physician _____ in City, State _____

Name of Emergency Contact _____ Phone _____

Name of Guardian, if this applies to Patient: _____ Relationship: _____

INSURANCE INFORMATION

Name of Primary Insurance _____ Secondary Insurance _____

Person Responsible for bill _____D.O.B. _____ Phone _____

Street Address (if different) _____ City, State & Zip _____

Occupation _____ Employer _____ in City, State _____

I acknowledge that I have been advised of Eye Physicians of Northampton's Notice of Privacy practices (copies are in waiting room for your viewing). I authorize the release of any medical information necessary to process claims for all visits. I also request payments be made payable and addressed to Eye Physicians of Northampton. I understand I am responsible for the payment of any non-covered service or any service/procedure that is applied to an annual deductible. I understand that I am responsible for getting any insurance referrals necessary for service/procedure provided by this office on the specified date of service.

_____ _____
Signature of Patient (or Guardian if applies) Date

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

If you have anyone you would like us to be able to share your medical information with (spouse, parent, guardian, child, etc.), please fill out the section below:

Name(s) _____ Phone _____ Relation _____

This release applied to any individually identifiable health information (Protected Health Care Information) governed and protected by the Health Insurance Portability and Accounting Act of 1966 (HIPAA), as amended, and under the rules and regulations thereunder. I, the above-signed patient or legal representative, hereby authorize Eye Physicians of Northampton to use, review, give, disclose and release the health, medical and mental health information and related records for the patient named above, to the recipients(s) named above. Method of release shall be pertinent to the need and may include photocopies, photographs, tax copies, scanned copies, postal mail, express mail, computer files, email, telephone, electronic or verbal communications.