CNY
Eye Care

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Gender: Birth date: Preferred to be called (if any): Email Address:

❑ M ❑ F / /

Street Address: Home phone no.:

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City: State: Zip Code: Cell phone no.:

( )

Occupation: Employer: Work phone no.:

( )

Chose CNY Eye Care because (please check one box): ❑ Dr. Referred (Doctor): ❑ Family ❑ Friend Who may we thank?

❑ Insurance ❑ Newspaper ❑ Close to home/work ❑ Yellow Pages ❑ Other

Physician: Phone: Address: Pharmacy: City:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.(if different):

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Occupation: Employer: Employer address: Work phone no.:

( )

Do you have medical insurance? ❑ Yes ❑ No Primary Insurance:

Subscriber's name: Birth date: Group no.: Policy no.: Co-payment:

/ / $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other Subscriber's Birth Date: / /

IN CASE OF EMERGENCY

Name of relative or friend (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CNY Eye Care or my insurance company to release any information required to process my claims.

Signature: **Date:**