NORTHERN KENTUCKY EYE CENTER – PATIENT REGISTRATION

Patient Name ____
Address __________________________________ **City/State**___________________ **Zip** __________
Sex ____ **Birth Date** _____________ **Age** ___ **Marital Status** ________ **SS# (last 4 digits)** ____________
Patient's employer or school __________________________________ **Occupation** _______________
Family physician and phone # ____
Medications currently using____
Medications allergic to____
Do you use any tobacco products? Yes / No Have you ever tested positive for HIV? Yes / No

Primary Insurance is _______________________**is policy under your name yes/no if no, name of that person** ____________________ **relationship to you** ____________ **address same as yours yes/no if no their address** ____ **their birthdate** _____________
last 4 digits of their social security # ____________
2nd Insurance is ____________________________**is policy under your name yes/no if no, name of that person** ____________________**relationship to you** _____________**address same as yours yes/no if no their address** ____**their birthdate**_____________
last 4 digits of their social security # ___________

When was your last eye exam? ____________________ **Do you currently wear glasses?** ____________
If yes, when did you purchase them? _________________ **Do you currently wear contacts?** ________

If patient is under 18 – name of adult accompanying patient and relationship ____________________
____ **Do you have guardianship?** _____
If you do not, name of person who does _________________________________ **and do you have their permission to bring child in for treatment?** ____________

AUTHORIZATION, RELEASE AND GUARANTEE OF ACCOUNT: I acknowledge that I am responsible for payment in full to Dr. Schaffield, for services rendered. I also authorize that benefits from insurance companies be paid directly to Dr. Schaffield. I authorize my physician to release any information required by my insurance carrier. If I have Medicare insurance, I certify that the information given by me in applying for payment under the Title XVIII Social Security Act is correct. I authorize any holder of medical or other information about me to release to the health care financing administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request that payment under the medical insurance program be made to Dr. Schaffield.

Date _____________________ **Signature** ____

Note: Please give the receptionist your health insurance card. If you do not have your current card with you, payment is expected today. We cannot bill your insurance until we have a copy of both sides of card. Thank you.