SOLOMON EYE PHYSICIANS & SURGEONS
REGISTRATION FORM

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	TITLE: MR. MRS. MS. MISS DR.	MARITAL STATUS: SINGLE DIVORCED MARRIED SEPARATED WIDOWED

IS THIS YOUR LEGAL NAME?	IF NOT, WHAT IS YOUR LEGAL NAME?	FORMER NAME:	BIRTHDATE: ____/____/____	AGE:	SEX: M / F

STREET ADDRESS:	APT/UNIT #:

CITY:	STATE:	ZIP:	SOCIAL SECURITY NUMBER:

EMAIL:	HOME PHONE #:	CELL PHONE #:
OCCUPATION:	EMPLOYER:	WORK PHONE #:
PHARMACY NAME:	LOCATION:	PHONE #:

CHOSE CLINIC BECAUSE/REFERRED TO CLINIC BY (PLEASE CHOOSE ONE OPTION):

☐ INTERNET ☐ FAMILY MEMBER ☐ TELEVISION ☐ MAGAZINE ☐ INSURANCE ☐ OTHER: _____

☐ MY OPTOMETRIST: _____ ☐ MY PCP: _____

INSURANCE INFORMATION

ARE YOU THE PRIMARY POLICY HOLDER FOR YOUR INSURANCE? YES NO

IF NO, NAME OF POLICY HOLDER: _____ DATE OF BIRTH ____/____/____

SOCIAL SECURITY NUMBER: _____

DO YOU HAVE A SECONDARY INSURANCE? YES NO ARE YOU THE PRIMARY POLICY HOLDER? YES NO

IF NO, NAME OF POLICY HOLDER: _____ DATE OF BIRTH ____/____/____

SOCIAL SECURITY NUMBER: _____

REFRACTION

A refraction is a measurement of the refractive error of your eyes. Our physicians complete this exam during most appointments in order to better calculate your best vision. Sometimes this refraction is done in order to establish the quality of your vision in the presence of certain diseases; other times for the purpose of dispensing contact lenses or glasses.

Most MEDICAL insurance companies will consider refraction as a non-covered service. Therefore, the charge for the refraction of $40.00, effective April 1, 2014 is the patient's responsibility and is payable at the time of service.

By signing below, you acknowledge that you have read the posted Practice's Privacy Note. Upon your request, we will provide you with a hard copy. You further acknowledge that you have read and understand the refraction policy.

_____ _____
Signature Date

HIPAA

I, _____, ALLOW MY PHYSICIAN OR HIS/HER OFFICE STAFF TO DISCUSS MY VISION, MEDICAL CONDITION OR ACCOUNT STATUS WITH THE FOLLOWING PERSON(S):

1. _____ 2. _____

THE FOLLOWING NUMBER IS SECURE AND CONFIDENTIAL. YOU MAY LEAVE A MESSAGE REGARDING MY APPOINTMENT AND/OR ANY OTHER INFORMATION THAT MAY NEED TO BE RELAYED TO ME IF YOU CANNOT REACH ME ON THE NUMBERS ABOVE. (_____) _____

I MAY NOTIFY THIS OFFICE IN WRITING AT ANYTIME TO RESCIND OR CHANGE ANY OF THE ABOVE INFORMATION.

_____ _____
Signature Date

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE:	RELATIONSHIP TO PATIENT:
HOME PHONE NUMBER:	WORK PHONE NUMBER:

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 **SOLOMON EYE PHYSICIANS & SURGEONS** OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION BE USED IN PLACE OF THE ORIGINAL. THE AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME IN WRITING.

PATIENT/GAUARDIAN SIGNATURE DATE