Medical Eye Services

PATIENT REGISTRATION

Patient: _____ _____ _____ _____ _____
Last Name First Name M.I. Date of Birth Age

Address: _____ _____ _____ _____
Street City State Postal Code

Social Security #: _____ E-Mail: _____

Phone: Home: _____ Cell: _____ Work: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact Name: _____ Phone: _____ Relation: _____

Primary Care Physician: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____ _____ _____
Street City State Postal Code

Office Phone: _____ Fax: _____

Insurance Cardholder or Legal Guardians' Information

Last Name: _____ First Name: _____ M.I. _____

Social Security#: _____ Gender _____ Date of Birth: _____

ASSIGNMENT AND RELEASE/ FINANCIAL AND BILLING POLICY

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Medical Eye Services all insurance benefits, if any otherwise payable to me for services rendered.

- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize the doctor or their agent to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- If you have any questions regarding this financial/billing policy please do not hesitate to contact our billing department at (847)662-4016

I have read and understand this statement: _____ _____
Patient/Parent Signature (Parent for Minor) Date

Medical Eye Services

Consent for Medical Procedures/ Disclose Medical Information

I, _____ give permission to the following people, power to consent for medical procedures and all treatment including any test results on my behalf including any medical information, financial information and any other information related to my visit with Medical Eye Services, Ltd.

Name	Relationship to patient	Phone #
Name	Relationship to patient	Phone #
Name	Relationship to patient	Phone #
Name	Relationship to patient	Phone #
Name	Relationship to patient	Phone #

_____ _____

(Patient signature) Date