Norton Eye Care PLLC

Registration Form

INTAKE DATE:_____ COMPLETED BY:_____

REFERRING PHYSICIAN:_____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____CITY:_____STATE_____ZIP:_____

SS#_____EMPLOYER:_____

PHONE:_____WORK:_____CELL:_____

SEX: FEMALE☐MALE ☐ MARITAL STATUS: SINGLE☐MARRIED☐DIVORCED☐

RESPONSIBLE PARTY:_____SS#_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE:_____CELL:_____DATE OF BIRTH_____

INSURANCE #1:_____

POLICY NUMBER:_____GROUP NUMBER:_____

POLICY HOLDER:_____PHONE:_____CELL:_____

INSURED'S DATE OF BIRTH:_____SS#_____

INSURANCE #2:_____

POLICY NUMBER:_____GROUP NUMBER:_____

POLICY HOLDER:_____PHONE:_____CELL:_____

INSURED'S DATE OF BIRTH:_____SS#_____

EMERGENCY CONTACT INFORMATION

NAME:_____RELATIONSHIP:_____

HOME PHONE:_____WORK:_____CELL:_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OUR BILLING COMPANY FOR PAPER AND ELECTRONIC BILLING TO YOUR INSURANCE COMPANY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL SERVICE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE NORTON EYE CARE PLLC'S BILLING COMPANY TO FILE FOR BENEFITS ON MY BEHALF FOR MEDICAL SERVICES RENDERED. INSURANCE PAYMENTS SHALL BE MADE DIRECTLY TO NORTON EYE CARE PLLC. IF I HAVE MEDICARE INSURANCE, I AUTHORIZE NORTON EYE CARE PLLC TO RELEASE TO THE SOCIAL SECURITY AND CARE FINANCING ADMINISTRATON OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES NOT PAID BY INSURANCE. THIS AUTHORIZATION IS VALID INDEFINITELY UNTIL REVOKED BY MYSELF OR BY NORTON EYE CARE PLLC.

SIGNATURE_____DATE_____