Monterey County Eye Associates

Patient Registration

Name: _____ Soc.Sec. #: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Sex: ☐ M ☐ F Age: _____ Birth date: _____ ☐ Single ☐ Married

Patient Employed by: _____ Business Phone: _____

Primary Care Doctor: _____ Referring Doctor: _____

In case of emergency who should be notified? _____ Phone: _____

☐ Confirm appointment via e-mail and/or receive recall notice E-Mail: _____

How did you hear about us? ☐ Internet ☐ Insurance ☐ Yellow Pages ☐ Radio ☐ Other: _____

☐ Established patient Name: _____

Primary Insurance

Name of Insured: _____
Last First Middle

Relation to Patient: _____ Birthdate: _____ Soc.Sec. #: _____

Person Responsible Employed by: _____ Phone: _____

Insurance Company: _____

Secondary Insurance

Name of Insured: _____
Last First Middle

Relation to Patient: _____ Birthdate: _____ Soc.Sec. #: _____

Person Responsible Employed by: _____ Phone: _____

Insurance Company: _____

CONTINUE ….

Insurance Assignment and Release

WE ARE CONTRACTED WITH MANY INSURANCE COMPANIES. HOWEVER, IT IS YOUR RESPONSIBILITY TO KNOW IF WE ARE CONTRACTED WITH YOUR INSURANCE. IF WE ARE NOT CONTRACTED WITH YOUR INSURANCE, BENEFITS MAY BE PAID DIRECTLY TO YOU BY YOUR INSURANCE COMPANY.

To: _____
Primary Insurance Secondary Insurance

I hereby authorize Monterey County Eye Associates to release to your insurance company or representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I also authorize and request your company to pay directly to the above named group the amount due in my pending claim for basic Medical and/or Surgical treatment or services, by reason of such treatment or services rendered to: _____
Patient Name

***I understand I am ultimately responsible for my account. I agree to pay co-pays, deductibles and anything not covered by my insurance plan including refractions and 20% of visit if I am insured with Medicare and do not have a secondary insurance.**

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

X_____ _____ _____
Responsible Party Signature Relationship (If under 18) Date