PATIENT REGISTRATION FORM

Today's Date: _____

Last Name:	First Name:	Date of Birth:
Primary Care Physician:	Responsible Party:	Relationship to Patient:

Street address:		City:	
State:		Zip code:	
Home Phone:		Work/Cell:	
Email:		Marital Status:	
Employer:		Referred by:	

Salutation: (circle one)	Mr. Mrs. Miss. Ms. Master	Suffix: (circle one)	Jr Sr
Sex: (circle one)	Male Female	Language: (circle one)	English Spanish Other:_____
Race:	☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other pacific Islander ☐ Other	Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino

INSURANCE INFORMATION

Name of Insured:	Date of Birth:	SSN:
Policy holder Relationship to patient:		
Insurance Company:	Type:	
Policy Number:	Group Number:	Co-Payment Amount:

CERTIFICATION AND ASSIGNMENT

I authorize the release of any medical or other information that is necessary to process my insurance claim(s) for myself and/or dependents and request that payment of government and/or insurance benefits be sent to Eye Practice of Nashua. I understand that I am financially responsible for all charges whether or not paid by Insurance.

Signature: _____ Date: _____ Relationship to patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (print name) _____ have received a copy of the Notice of Privacy Practices for this office.

Signature:_____ Date:_____