



New Patient Registration

Please verify the following information, make necessary changes and supply any missing information.

						Today's Date	
Patient Information							
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Nickname	Date of Birth	Age	Sex	
Street Address			City, State	Zip Code			
Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)			
Race: Please Circle One White/Caucasian Black or African American Native Hawaiian/Pacific Islander American Indian/Alaska Native Asian Other _____ Decline to answer			Primary Language	Ethnicity: Please Circle One Not Hispanic or Latino Hispanic or Latino Decline			

HIPAA Contact (Approved to discuss/release medical information)

Name	Phone Number
Relationship to the patient	Is this person also your Emergency Contact: Yes _____ No _____ If No: Name: _____ Phone: _____

Primary Insurance

Vision Insurance

Insured's Name	Date of Birth	Insured's Name	Date of Birth
ID Number	Group Number	ID Number	Group Number
Insurance Company Name	Insurance Co. Phone	Insurance Company Name	Insurance Co. Phone

Primary Care Physician: _____ **Phone:** _____
Town: _____ **Fax:** _____
Pharmacy and location _____

INSURANCE AUTHORIZATION:

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Illinois Eye Associates, Ltd. all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or personally. I authorize the use of my signature on all insurance submissions. If my bill is not paid by insurance, I understand I am responsible for any charges. A \$25 fee will be applied to all checks with insufficient funds.

Illinois Eye Associates may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I further consent to the disclosure of my health information in order for another provider or health care entity to conduct health care operations, including quality assessment and reviewing the competence of health care professionals. I consent to allowing Illinois Eye Associates to obtain my previous records from other health care providers if deemed necessary for my care.

I further acknowledge that Illinois Eye Associates, Ltd. has made available to me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature: _____ **Date:** _____ **Relationship to Patient:** _____

Name: _____ **DOB:** _____ **Date:** _____

