

SHASTA EYE MEDICAL GROUP, Inc. PATIENT REGISTRATION INFORMATION

Please print all information – Thank you!

Chart # _____

Patient's Personal Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Social Security # _____ Single / Married / Other _____ Male / Female _____

Mailing Address _____ Apt # _____ City _____ State _____ Zip _____

Email Address _____ Home Phone (____) _____ Work Phone (____) _____

Driver's License # / Issuing State _____ Employer _____ Employer's Phone (____) _____

Primary Care Physician _____ Address _____ Phone _____

Spouse First Name _____ Spouse Last Name _____ Spouse DOB _____ Social Security # _____

Account Responsible Party Information

Responsible Party's Name _____ Relationship to Patient Self Spouse Parent Other

If not Self, Responsible Party _____ (____) _____
Address _____ Home Phone _____ SS# _____ DOB _____

Emergency Contact and Protected Information Release Authorization

Emergency Contact
(Person not living with you) Name _____ Relationship _____

Address _____ City, State, Zip _____ Phone (____) _____

Personal / Protected Health Information may be given to the following person(s).

Name _____ Address _____ Relationship _____

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Shasta Eye Medical Group, Inc., and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and to initiate a complaint to the Insurance Commissioner on my behalf if necessary. I also acknowledge the receipt of information on the privacy policy of this practice governed by HIPAA. I further agree that a photocopy of this agreement shall be as valid as the original.

YOUR SIGNATURE _____ **Date** _____