SHASTA EYE MEDICAL GROUP, Inc. PATIENT REGISTRATION INFORMATION

Please print all information – Thank you!

Patient First Name ______ Middle Initial ______ Last Name ______

___/___/___ Date of Birth ______ ___-___-___ Social Security # ______ Single / Married / Other ______ Male / Female (circle one)

Mailing Address ______ Apt # ______ City ______ State ______ Zip ______

___@___ Email Address ______ ( ) Home Phone ______ ( ) Work Phone ______ ( ) Cell Phone ______

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

Primary Care Physician ______ Address ______ ( ) Phone ______

Preferred Communication Method: ☐Home Phone ☐Work Phone ☐Cell Phone ☐Secure Email ☐US Mail

Preferred Language: ☐English ☐Spanish ☐Other: _________

Race: ☐Decline to Answer ☐White ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐More than one Race

Ethnicity: ☐Decline to Answer ☐Hispanic or Latino ☐ Not Hispanic or Latino

Spouse First Name ______ Spouse Last Name ______ ___/___/___ Spouse DOB ______ ___-___-___ Social Security #: ______

How did you choose us for your eye care? Referred by: ☐ Doctor______________ ☐Family/Friend:__________________

☐ Radio/TV ☐Newspaper ☐Insurance Directory ☐ Yellow Pages ☐Other, please describe

Account Responsible Party Information

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

If not Self, Responsible Party______________________________ ( )
Address ______ Home Phone ______ SS# ______ DOB ______

Emergency Contact and Protected Information Release Authorization

Personal / Protected Health Information may be given to the following person who is also emergency contact:

Name ______ Relationship ______

Address ______ City, State, Zip ______ ( ) Phone ______

Assignment of Benefits * Financial Agreement

I hereby give 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. **I understand there is a $40 charge for the diagnostic vision test known as a refraction that my insurance may not cover.** 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**__________________