David E. Palozej Eyecare Associates, LLC
Insurance Registration Form

Please fill out all information to the best of your ability!
We apologize for this inconvenience, but due to changes in computer systems and insurance company requirements, we cannot efficiently care for you without this data.

Todays Date _____/_____/_____

Patient Name: Last _____First_____Middle_____

Address 1: _____

Address 2: _____

City _____ **State** _____ **Zip Code** _____

Sex Please circle: M F **Home #** ( ) _____-_____ **Work #** ( ) _____-_____

WHAT IS THE BEST NUMBER TO REACH YOU DURING THE DAY? _____

Birthdate: _____/_____/_____ **Age:** _____ **SS#:** _____-_____-_____

Employer: _____ **Address** _____ **Occupation**_____

Patient's Primary Care Doctor: _____ **Phone/Town**_____

I Prefer to be called/Nickname: _____ **Marital Status** Please circle: M S D W

Bill to/Guarantor: Last _____ First _____ Middle _____

Is Guarantor's address same as patient's? Please circle: Yes No (For Mailing Purposes)

Insurance Company 1: _____ **I.D.#** _____

Subscriber: Last _____ First _____ MI ___ **DOB** ____/____/_____

Patient's Relation to Subscriber? Please circle: Self Spouse Child Other _____

Insurance Company 2: _____ **I.D.#** _____

Subscriber: Last _____ First _____ MI ___ **DOB** ____/____/_____

Patient's Relation to Subscriber? Please circle: Self Spouse Child Other __

Please turn over and fill out reverse side!!

A friendly reminder: It is the patient's responsibility to obtain any referrals that may be required!!!

Consent and Acknowledgment Form

Explanation of Privacy Policies

Signing this form allows us to send your treatment information to insurance carriers.
Signing this form allows us to electronically bill your insurance company.
Signing this form also allows us to send information to other healthcare providers.
Failure to sign will require you to ***pay for each visit in full*** at the time of treatment and you will need to submit our bill to your own insurance company on your own.

I understand that the information that I have given today is correct to the best of my knowledge. I also know that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes. I authorize the doctor's optometric staff to perform any optometric service with my informed consent.

I consent to the use or disclosure of my health information by David E. Palozej Eyecare Associates LLC for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations.

Signing this document also signifies that you have received a copy of our Notice of Privacy Practices (HIPAA)

Please sign this form only ***ONE TIME*** per year!!

_____

Patient's Signature Date

_____

Patient's Signature Date

_____

Patient's Signature Date

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Patient's Signature Date