HOMETOWN EYE CARE

PATIENT INFORMATION

Registration / HIPAA / Insurance

PATIENT REGISTRATION

Full Name	Date of Birth	Social Security #
Address Street	State	Zip Code
Home Phone	Cell Phone	Email

How would you like us to contact you ? [ ] Home Phone [ ] Cell Phone

Primary Care Physician

Emergency Contact (Full Name)	Telephone

Employed (Please Check) [ ] FT [ ] PT [ ] Self Employed [ ] Retired [ ] Other

Military Status (Please Check) [ ] Active Duty [ ] Reserves [ ] Retired [ ] Non Military

Student Status (Please Check) [ ] FT [ ] PT [ ] Non a Student

Employer Name & Telephone Number

HIPAA - DISCLOSURE OF INFORMATION

May we leave message on your home telephone answering machine to confirm appointments?	[ ] YES	[ ] NO

If you would like us to be able to discuss your eye care with anyone other than yourself, please list the name, relationship and telephone number

Full Name	Relationship	Telephone
Full Name	Relationship	Telephone

I have been offered a copy of or have read the Hometown Eye Care, PLLC "Notice of Privacy Practices" Your Initials _____

INSURANCE INFORMATION

Primary Insurance				Certificate Number
Subscriber				Group Number
Patient Relationship to Subscriber (Please Check)				Subscriber Date of Birth _____/_____/_____
[ ] Self	[ ] Spouse	[ ] Child	[ ] Other	Subscriber Employer
Secondary Insurance				Certificate Number
Subscriber				Group Number
Patient Relationship to Subscriber (Please Check)				Subscriber Date of Birth _____/_____/_____
[ ] Self	[ ] Spouse	[ ] Child	[ ] Other	Subscriber Employer

INSURANCE AUTHORIZATION & CONSENT

I hereby authorize Hometown Eye Care, PLLC to furnish information to insurance carriers concerning my illness and treatments and i hereby assign to the physician(s) all payments for medical services rendered to my dependednt or myself. I understand that i am responsible for any amount not covered by my insurance.

Signature (Patient or Representative)	Date

17 Boynton Lane, Littleton NH 03561 | 603-259-1400 | Fax: 603-259-1403 | HometownEyeCareNH.com