



# HOMETOWN EYE CARE

## PATIENT INFORMATION

Registration / HIPPA / 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 ? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone				
Primary Care Physician				
Emergency Contact ( Full Name)				Telephone
Employed (Please Check) <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Other				
Military Status (Please Check) <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserves <input type="checkbox"/> Retired <input type="checkbox"/> Non Military				
Student Status (Please Check) <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Non a Student				
Employer Name & Telephone Number				
HIPPA - DISCLOSURE OF INFORMATION				
May we leave message on your home telephone answering machine to confirm appointments?			<input type="checkbox"/> YES	<input type="checkbox"/> 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 ____/____/____	
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	Subscriber Employer
Secondary Insurance			Certificate Number	
Subscriber			Group Number	
Patient Relationship to Subscriber ( Please Check)			Subscriber Date of Birth ____/____/____	
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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