

# Eye Care Registration

Today's Date \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex: M F

Occupation \_\_\_\_\_ Employer or School \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Insurance	Acknowledgement of Notice of Privacy Practices															
<p>Policy Holder: _____                      Relationship to Policy Holder: self spouse child other</p> <p>Insurance Company: _____                      ID#: _____ Group#: _____                      Is patient covered by additional insurance? Yes No</p> <p>Policy Holder: _____                      Relationship to Patient: self spouse child other</p> <p>Insurance Company: _____                      ID#: _____ Group#: _____</p>	<p>I acknowledge I have been offered a copy of the Privacy Practice for Ozark/Shell Knob Eye Clinic. I understand the content of the notice of Privacy Practice. I give Ozark/Shell Knob Eye Clinic permission to leave a message on my answering machine or talk with the individuals I have listed regarding appointments, insurance or billing questions, or reports, if I am not available. I consent to primary eye care, optical services, and medications prescribed by Ozark/Shell Knob Eye Clinic.</p> <p>_____                      Signature of Patient or Personal Representative</p> <p>Date: _____</p>															
Assignment and Release	<p>Who may we leave a message with or allow to pick up glasses, contact lenses, eye drops, reports, etc.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%; text-align: center;">Name</th> <th style="width: 33%; text-align: center;">Relationship</th> <th style="width: 33%; text-align: center;">Phone#</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Name	Relationship	Phone#	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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<p>I hereby certify that I, and/or my dependent(s) have insurance coverage and assign directly to Ozark <b>OR</b> Shell Knob Eye Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.</p> <p>Ozark <b>OR</b> Shell Knob Eye Clinic may use my health care information and may disclose such information to the above named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end two years from the date signed below.</p> <p>_____                      Signature of Patient, Parent, Guardian or Personal Representative</p> <p>_____                      Please print name of Parent, Guardian or Personal Representative</p> <p>Date _____ Relationship to Patient _____</p>	<p>Who may we thank for referring you?</p> <p>_____</p>															