Horizon Eye Care Group, P.C. **Patient Registration Form**

First Name: _____ Last Name: _____ MI: _____

Street Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email Address: _____

Date of Birth: ___/___/_____ SSN: _____ ☐ Male ☐ Female

Maritial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: *(Circle One)* Hispanic/Latino Not Hispanic/Latino Prefer not to Answer

Race:_____

Primary Care Provider: _____ Telephone Number: _____

Parent/Guardian/Responsible Party and/or insured party *(to be completed only if different from patient)*

Name: _____ Relationship to Patient:_____

Street Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: ___/___/_____ SSN: _____ Male Female

Employer: _____ Occupation: _____

Employer's Street Address: _____
City: _____ State: _____ Zip: _____

Work Phone: _____

In Case of Emergency Please Contact:

Name: _____ Telephone Number: _____ Relationship:_____

Your insurance policy is a contract between <u>you and your insurance company</u>. We will submit insurance claims to your insurance carrier for services rendered if you have given us complete and accurate insurance information. We must have the correct policy, group, ID or claim numbers, and mailing address. Please be aware that some, or perhaps all, of the services provided to you may be non-covered services according to your insurance policy. You are ultimately responsible for payment of all services provided to you. By signing below, you state that you understand the above policy and that you authorize Horizon Eye Care Group, P.C. to release any medical information necessary to your insurance company in order receive payment on your behalf.

Signature: _____ Date:_____