Registration : Eye Care Specialists, PS

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Phone

Pref Language:	Race:	Ethnicity:	County:

Provider	Family Physician	Referring Physician

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

Patient's or Authorized Person's Signature

I the undersigned give my authorization to provide medical, nursing, emergency care or such treatment as necessary and assign directly to Eye Care Specialists, PS , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for applicable late fees, finance charges and handling charges. I agree to pay all applicable charges and fees. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Eye Care Specialists, PS 500 Port Drive Clarkston, WA 99403	Phone: 509-758-8811 Email:
X			

Please attach all pertinent insurance ID cards for photocopying.