NORTHWEST EYE SPECIALISTS, PLLC
REGISTRATION FORM

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Language:	SSN:	Nickname:

Street Address:	Cell phone: ( )	Home phone: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Relationship to patient:	

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Cell Phone ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize Northwest Eye Specialists, L.L.C., dba Fishkind, Bakewell, Maltzman & Hunter Eye Care and Surgery Center to release to the Social Security Administration & the Center for Medicare & Medicaid Services or its intermediaries or carriers any information needed for any Medicare or private insurance claim. I permit a copy of this authorization to be used in place of the original & request payment of insurance benefits be paid to Northwest Eye Specialists, L.L.C. Regulations pertaining to Medicare assignment of benefits apply.

Patient/Guardian signature *Date*