

**Registration :**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact			Phone		Pharmacy		Pharmacy Phone

<b>Physician</b>	<b>Family Physician</b>	<b>Referring Physician</b>
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Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

**Guarantor (Person to be billed, if different than patient)**

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation
2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	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:

**CMS / ONC Electronic Health Record requirement.**

**Ethnicity:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Language:** \_\_\_\_\_

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to Eye Care Center of No. Co. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all approved and covered charges whether or not paid by insurance. 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 treatment, obtaining payment of benefits and for services rendered. I consent to be contacted by mail, email or cell phone regarding any matter related to my Eye Care Center accounts by the provider, creditor, its successors, 3rd party collection agencies or assigns. This consent includes contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. To revoke consent to call my cell phone, I agree to provide notice by mail to Eye Care Center of No. Co. 1400 Dry Creek Dr. Longmont, Co 80503

<b>Signature</b>	<b>Signature Date</b>	<b>Eye Care Ctr Of North CO, PC</b>	<b>Phone: 303-772-3300</b>
<b>X</b>		Lockbox Op, PO Box 22057 Tempe, AZ 85285	Email:

**Please attach all pertinent insurance ID cards for photocopying.**