SHARP EYE CONSULTANTS

Patient Registration Information

Patient Name _____ Sex ____ M _____ F

Social Security # _____ Birth Date _____ Age _____

Patient Address _____City/St. _____ Zip code _____

Home Phone (____)_____ Work Phone (____)_____

Emergency Contact/Relationship _____Phone # _____

Marital Status Single -- Married -- Widowed -- Divorced

Insurance Information:

Insurance name:_____ Policy Holder Name: _____

D.O.B of Policy holder: _____ Social Security # of policy holder _____

Group # _____ ID #_____

Referred By _____

Family Doctor _____ (__) Same as Referring Physician

I authorize the release of any medical information necessary to process all claims.

Patient/Guardian Signature X_____ Date _____

Financial Responsibility

Positive verification of your coverage cannot be made at this time. You will receive services today with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services rendered.

Subscriber _____ Signature X_____ Date _____