



Rochester Eye Associates, P.C.

"Eye care for all ages"

2301 Lac De Ville Blvd.
Rochester, NY 14618
(585) 244-0332

1016 Elmgrove Road
Rochester, NY 14624
(585) 429-5330

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, M.I.)		Sex	Date of Birth
Check One: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Prof. <input type="checkbox"/> _____		Social Security Number	Occupation
Address		City	Zip
Employer / Address		Phone	
How Long?	Business Phone	Patient Status (check all that apply) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____ <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Student Full Time <input type="checkbox"/> Student Part Time	

VERY IMPORTANT: IF PERSON RESPONSIBLE FOR PAYMENT IS DIFFERENT THAN SHOWN ABOVE, THIS PORTION MUST BE COMPLETED

Name (Last, First, M.I.)	DOB	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number	Relationship To Patient
Address		City	Zip	Phone
Employer / Address				
How Long?	Business Phone	Patient Status (check all that apply) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____ <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Student Full Time <input type="checkbox"/> Student Part Time		

INSURANCE AND OTHER INFORMATION

Insurance Policy 1	Policy or Identification Number	Subscriber's Name
Insurance Policy 2	Policy or Identification Number	Subscriber's Name
Worker's Compensation Carrier / Address and Phone Number		
Referring Practitioner	Patient's Primary Care Doctor	
Why did you select our office?		

PLEASE COMPLETE PORTION ON REVERSE SIDE

PATIENT REGISTRATION INFORMATION

The office policy is to require payment at the time of service by check, cash, or credit card. HMO patients (Blue Choice and Preferred Care) are required by contract to pay the co-payment at the time of service. You are responsible for telling us about changes in your insurance status. We will not be held liable for errors caused by failure to notify us of changes. There may be a charge of \$25.00 for broken appointments without a 24 hour notification.

Upon ordering contact lenses or eyeglasses, a 50% deposit is due with the balance due at dispensing.

ASSIGNMENT OF BENEFITS -- INFORMATION RELEASE FINANCIAL RESPONSIBILITY -- COLLECTION FEES

I assign all medical / surgical benefits to Rochester Eye Associates, P.C. I further authorize the release of all or any part of my medical record and/or financial ledger to a health insurance agency listed on the reverse side to secure payment for services rendered or to complete disability forms presented to me. I understand that I am financially responsible for all charges whether or not paid by said insurance agencies. If the amount is referred for collection, I agree to pay for attorney's fees, court costs, and other reasonable costs of collection.

A photocopy of this assignment and authorization is considered as valid as the original. This authorization will remain in effect until revoked in writing.

I have completed this form to the best of my knowledge and understand the policies above.

Signed: _____ Date: _____
(Patient, Guardian, Responsible Individual)

CONSENT FOR MINORS

I give permission for the providers at Rochester Eye Associates to examine and/or treat

(Patient name)

Signed: _____ Date: _____
(Parent, Guardian)