



REGISTRATION FORM 2012
PLEASE COMPLETE THE FORM BELOW

Acct# _____

PLEASE PRINT - PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Social Security # _____ Sex (Please Circle) M F

Race _____ Marital Status _____ Email Address: _____

We will occasionally contact you via email and provide information about Florida Eye Center announcements, services and offerings that may be of interest to you. If you prefer not to receive such emails please check here. No

Street Address _____

City/ST/Zip _____ Home Phone _____ Cell Phone _____

(If Applicable, Please Provide Seasonal Address: Street _____

City _____ State _____ Zip _____ Home Phone _____)

Occupation _____ Employer _____ Work Phone _____

Responsible Party If Other Than Self (Relationship): _____

Emergency Contact Name AND Relationship _____ Phone Number _____

How did you hear about us? Friend / Family Insurance Phone Book Website Newspaper
 Magazine Dr. _____ Other _____

Primary Care Physician Name _____ PCP Phone # _____

VISION INSURANCE

Insurance Company Name _____ Phone Number _____

Policy # _____ Group # _____ Subscriber _____

Insurance Address: _____

Subscriber Social Security # _____ Subscriber Date of Birth _____

Subscriber Marital Status _____ Relationship to Subscriber _____

PRIMARY MEDICAL INSURANCE

Insurance Company Name _____ Phone Number _____

Policy # _____ Group # _____ Subscriber _____

Insurance Address: _____

Subscriber Social Security # _____ Subscriber Date of Birth _____

Subscriber Marital Status _____ Relationship to Subscriber _____

Acct# _____

PATIENT NAME _____ DATE OF BIRTH _____

SECONDARY MEDICAL INSURANCE

Insurance Company Name _____ Phone Number _____

Policy # _____ Group # _____ Subscriber _____

Insurance Address: _____

Subscriber Social Security # _____ Subscriber Date of Birth _____

Subscriber Marital Status _____ Relationship to Subscriber _____

FLORIDA EYE CENTER FINANCIAL POLICY

I understand that copays and deductibles are paid at the time services are rendered. I understand it is my responsibility to provide Florida Eye Center with my current insurance card and information, and to obtain any referrals or authorizations necessary. I understand that I will be held financially responsible for any charges that are not paid by my insurance company. I agree and understand that there will be a \$30.00 fee for each check returned for insufficient funds.

PATIENT SIGNATURE

DATE

**NON-MEDICARE PATIENTS & MEDICARE PATIENTS WITH A
SECONDARY INSURANCE – LIFETIME AUTHORIZATION (Please sign below)**

**INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF
PAYMENTS: (THIS IS NEEDED TO BILL YOUR INSURANCE)**

I hereby authorize Florida Eye Center to release any information to my insurance company(s) that is necessary to process my medical claims. I further authorize all insurance payments be made directly to Florida Eye Center.

I further understand that even though Florida Eye Center verifies my insurance coverage, until my insurance company processes my claims and produces an Explanation of Benefits that any quote of my financial responsibility by Florida Eye Center is subject to change.

PATIENT/GUARDIAN SIGNATURE

DATE

MEDICARE PATIENTS – LIFETIME AUTHORIZATION (Please sign below)

I hereby authorize Florida Eye Center to release any information to Medicare that is necessary to process my medical claims.

I further authorize all Medicare payments be made directly to Florida Eye Center.

I understand that I will be held financially responsible for my deductible and any balance not paid by my insurance carrier.

PATIENT/GUARDIAN SIGNATURE

DATE

Acct# _____

PATIENT NAME _____

DATE OF BIRTH _____

REFRACTIONS – ALL PATIENTS MUST SIGN

A refraction is a measurement of the lens power of your eyes. A refraction test is necessary to perform to obtain a glasses and/or contact lens prescription.

Most health insurance companies do not consider a refraction to be a covered benefit.

Medicare does not consider refractions to be a covered service; therefore, the patient is responsible for the cost of the refraction.

I agree that the cost of the refraction is my responsibility if my insurance does not consider a refraction a covered benefit.

PATIENT/GUARDIAN SIGNATURE

DATE

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye.

Dilating drops blur vision and may cause bright lights to be bothersome. The severity and duration varies from person to person. It is not possible for your doctor to predict how much your vision will be affected. Driving may be difficult immediately after a dilated examination, therefore it may be best for you to make arrangements not to drive yourself if you are bothered by the symptoms of dilation.

I hereby authorize the doctors at Florida Eye Center and/or such assistants as may be designated by them to administer dilating drops. I understand that eye drops are necessary to diagnose my condition and/or examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at Florida Eye Center.

PATIENT/GUARDIAN SIGNATURE

DATE