DRAGA EYE CARE **REGISTRATION FORM**

Today's Date: _____

Last Name:_____ First Name: _____ MI:___ ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr.

Date of Birth:_____/_____/_____ Age: _____ Male: ___ Female:_____ Marital Status: ❑married ❑single
Mo day yr ❑divorced ❑widowed ❑other

_____ _____ _____ _____ _____
Social Security # Home phone Cell phone Work Phone email

_____ _____ _____ _____ _____
Street Address apt # City State Zip Code
_____ _____ Contact preference: phone: ❑Work ❑home ❑cell
Occupation/employer Address

REFERRED BY: PHYSICIAN: _____PATIENT:_____ Other:_____

EMERGENCY CONTACT:_____ Relationship:_____ Phone:_____

DEMOGRAPHICS

RACE: ❑African American ❑Asian ❑Caucasian ❑Hispanic ❑Native American ❑Other
ETHNICITY: _____
PRIMARY LANGUAGE: ❑English ❑Greek ❑Spanish ❑Italian ❑French ❑Other_____

PHARMACY/ PHYSICIAN INFORMATION

Pharmacy Name: _____ Address: _____Phone: _____

Primary Care Physician: _____ Address: _____
Phone:_____ Fax:_____
Endocrinologist: _____Address: _____
Phone:_____ Fax:_____

INSURANCE INFORMATION

Person Responsible for bill: ❑self ❑Other : _____relationship: ❑spouse ❑parent ❑child

Primary Insurance: _____ Address: _____ phone:_____
Subscriber's name:_____ Subscriber S.S.#:_____Birthdate:_____
Group#:_____Policy#:_____
Patient's relationship to subscriber: ❑Spouse ❑Parent ❑Child

Secondary insurance:_____ Address: _____phone:_____
Subscriber's name: _____ Subscriber S.S.#:_____Birthdate:_____
Group#:_____Policy#:_____

Private Insurance/Self Pay: I understand that I am individually responsible for the full payment of the fee for services rendered to me by this office. I understand that all medical care provided to me or my child is on a fee for services basis. I authorize my insurance benefits to be paid directly to the physician. I am responsible for the balance and all copays. Copays are paid at the time of visit. Payment is expected at time of visit unless we participate in your plan Medicare: I request that payment of authorized Medicare benefits be made directly to Draga Eye Care on my behalf for any medical services furnished to me. I authorize the release of medical information about me to any health care financing administration and its agents, needed to determine these benefits payable for related services. I hereby assign all benefits to Draga Eye Care. I understand that I am responsible for all charges not paid by my insurance. I have received the HIPAA Notice of Privacy Practices and I have had the opportunity to review it and take a copy for my records.

Patient / Guardian Signature_____Date:_____

Revised aed 11/2014