CIRCLE CITY
NEURO-OPHTHALMOLOGY

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New Patient Registration Form

Patient Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: □ M □ F SSN: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Email: _____

Preferred Method of Contact: □ Home □ Work □ Cell Email

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Decline to Answer

Race: □ American Indian or Alaska Native □ Black or African American □ White □ Asian
□ Native Hawaiian or Pacific Islander □ Decline to answer □ Other: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Spouse's Name: _____ Date of Birth: _____

Spouse's Phone: (_____)_____ Spouse's SSN: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Address (if different from patient): _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ Alternate Phone: (_____)_____

Responsible Party *(if different from the patient)*

Name: _____ Relationship to Patient: _____

Address (if different from patient): _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ Alternate Phone: (_____)_____

Referring Physician Information

Referring Physician: _____ Phone: (_____)_____

Primary Care Provider (if different): _____ Phone: (_____)_____

Please list any other physicians who are currently caring for your medical condition and whom you wish to notify about your neuro-ophthalmology exam:

Physician: _____ Specialty: _____ Phone: (_____)_____

Physician: _____ Specialty: _____ Phone: (_____)_____

Physician: _____ Specialty: _____ Phone: (_____)_____

Physician: _____ Specialty: _____ Phone: (_____)_____

Physician: _____ Specialty: _____ Phone: (_____)_____

Pharmacy Information

Preferred Pharmacy: _____ Phone: (_____)_____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

I prefer: □ 30-day □ 60-day □ 90-day

Medical Insurance Information

Insurance Carrier: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ SSN: _____

Secondary Carrier: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ SSN: _____

Insurance Release of Information

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the Payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.

X_____

Signature of Patient or Legal Guardian

Financial Responsibility Statement

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, or other third-party payor. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.

X_____

Signature of Patient or Legal Guardian

Authorization for Release of Records

If you do not wish to have any of your medical information shared with anyone other than the physician who referred you, you do not need to complete this section.

This authorization is used when either you (the patient), or the treating physician has a specific desire or need to share all or any portion of your protected health information (PHI) medical records with a guardian, other family members, or healthcare providers not already involved in your care.

Name of person(s) and/or organizations authorized to receive information:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

X_____

Signature of Patient or Legal Guardian

Acknowledgement of No-Show/Last Minute Cancellation Fee

I accept responsibility for notifying Circle City Neuro-Ophthalmology if I know I will be late or unable to show for my appointment. I understand that if I do not provide at least 24 hours of advance notice to cancel or reschedule my appointment, or if I do not show for my appointment, I may be charged a $75.00 service fee by Circle City Neuro-Ophthalmology.

X_____

Signature of Patient or Legal Guardian