LONG ISLAND EYE SURGEONS, P.C. Today's Date: __________

Patient Registration

Name: ______________________ ______________________ __________
LAST FIRST MIDDLE INITIAL

Date of Birth: __________ Social Security #: ______________ Sex: ☐ Female ☐ Male

Address: ______________ ________ __________ ________ ______
STREET APARTMENT # CITY STATE ZIP

Phone #: (______) __________- __________ Cell #: (______) ________ - ________

Patient's Employer: ______________________ Work #: (______) ________ - ________

Employer's Address: ______________________

Financially Responsible Party: ☐ ***Same as above*** *(if not, please fill in below)*

Name: ______________________ ______________________ __________
LAST FIRST MIDDLE INITIAL

Date of Birth: __________ Social Security #: ______________ Sex: ☐ Female ☐ Male

Address: ______________ ________ __________ ________ ______
STREET APARTMENT # CITY STATE ZIP

Phone #: (______) __________- __________ Cell #: (______) ________ - ________

Emergency Contact Name: ______________ Phone #: (______) ________ - ________

Primary Physician: ______________ Phone #: (______) ________ - ________

Address: ______________________ Fax #: (______) ________ - ________

Insurance Information

Primary Insurance: ______________________ Effective date: __________

Policy #: __________ Group #: __________ Policy Holder's S.S. #: __________
IF DIFFERENT FROM ABOVE

Insured's Name: ______________________ Insured's Date of Birth: __________

Relationship: ☐ Spouse ☐ Parent

Secondary Insurance: ______________________ Effective date: __________

Policy #: __________ Group #: __________ Policy Holder's S.S. #: __________
IF DIFFERENT FROM ABOVE

Insured's Name: ______________________ Insured's Date of Birth: __________

Relationship: ☐ Spouse ☐ Parent

To my insurance carrier(s):

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Medical Management Technologies.
2. I authorize the request for payment of medical benefits directly to my physicians, Long Island Eye Surgeons, P.C.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that all photocopies of this form may be used in lieu of the original.
5. I agree to pay all charges not covered by my insurance carrier(s): these charges include, but are not limited to, deductibles and co-payments of my insurance policy.

Signature ______________________________ Date __________

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