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: _____

INSURANCE INFORMATION - YOU MUST PROVIDE US WITH CURRENT INSURANCE CARDS

Insured's name if different from patient: _____ Date of Birth:_____

Relationship to Patient _____

Address if different from Patient: _____ Phone Number: _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____

PRIMARY PHYSICIAN

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone Number: _____

Pharmacy Address: _____

To my insurance carrier(s):

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize the request for payment of medical benefits directly to my physicians, Long Island Eye Surgeons, P.
3. I agree to pay all charges not covered by my insurance carrier(s); these charges include, but are not limited to, deductibles and co-payment of my insurance policy.

Signature _____ Date_____

3.16 Rev.