

Registration :

Eye Care Center Of Northern Colorado, PC

Date	Account ID	Chart ID	Other ID	Internal Use
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Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact			Phone		Pharmacy		Pharmacy Phone

Physician	Family Physician	Referring Physician
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Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)							
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation	
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation	

HIPAA Approved Contacts							
1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature		
<p>I the undersigned give my authorization to treat and assign directly to Eye Care Center Of Northern Colorado, PC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.</p> <p>I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.</p>		
Signature	Signature Date	<p>Eye Care Center Of Northern Colorado, PC 1400 Dry Creek Drive Longmont, CO 80503</p> <p>Phone: 303-772-3300 Email:</p>
X		

Please attach all pertinent insurance ID cards for photocopying.