8244 E US Hwy 36 Ste 200 Avon, IN 46122 317-272-2020

PATIENT REGISTRATION

NAME: ____ NICKNAME: ________________________

DATE OF BIRTH: _______________________________ AGE: ____________

ADDRESS: ____

STREET CITY STATE ZIP CODE

TELEPHONE: HOME: ________________________ CELL: ___________________________

PLEASE CIRCLE PRIMARY PHONE

EMAIL ADDRESS: ____

SOCIAL SECURITY NUMBER: _________________________________

NAME OF SPOUSE: ____

HOW DID YOU HEAR ABOUT US? : ____

EMERGENCY INFORMATION

EMERGENCY CONTACT: ____

PHONE: _______________________________ RELATIONSHIP: _______________________

RESPONSIBLE PARTY

If patient is a minor or there is a responsible party (or P.O.A.) for taking care of bills please provide contact information below.

RESPONSIBLE PARTY NAME: ______________________________DOB:_________________

PHONE: _________________________________

ADDRESS: ____

STREET CITY STATE ZIP CODE

Can we share your medical information with this person? ______ yes _______no

Physician Information:

REFERRING PHYSICIAN: ______________________________ PHONE: __________________

PRIMARY CARE PHYSICIAN: ___________________________ PHONE: __________________

DIABETIC PHYSICIAN: ________________________________ PHONE: __________________

PHARMACY: ____ PHONE: __________________

WORKER'S COMPENSATION

(Please complete if this is a worker's compensation claim)

Employer Name: ____

Address: ____

City State Zip Code

Phone: ________________________________ Claim #: _____________________________

Contact person: ____

RELEASE OF INFORMATION AUTHORIZATION:

I hereby authorize Whipple Eye Center to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I understand I am financially responsible for any fees not paid by for insurance. I hereby authorize and direct my insurer to issue payment checks for benefits due me for the services rendered by Whipple Eye Center to be paid directly to them.

I authorize the Whipple Eye Center to leave messages about my upcoming appointments and procedures at the above listed phone numbers.

_______________________________________ ________________________

SIGNATURE DATE