CARABIN EYE CARE
Medicine & Surgery of the Eye

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age	Home Phone#
Address	Apt#	City	State	Zip		
SS#	Work#	Occupation	Marital Status			
E-Mail	Cell Phone#	Primary Care Physician	Phone#			
Employer Name/Address	City	State	Zip			
Emergency Contact	Relationship	Phone#				

INSURANCE

Primary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		
Secondary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		

WORKMENS COMP.

Is this work related? ( ) Y ( ) N	Date of injury	Claim#
Workmans Comp. Insurance & Address		
Attorney Name & Address		

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

ASSIGNMENT OF BENEFITS:
I hereby assign or transfer payment benefits made to me and my behalf to Carabin Eye Care, P.C. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION:
I hereby authorize Carabin Eye Care, P.C. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Patient Signature: _____ Date: _____