HATTIESBURG EYE CLINIC, P.A.

100 West Hospital Drive
Hattiesburg, MS 39402
(601) 268-5910

Today's Date ______________

PATIENT REGISTRATION

PATIENT

First Name ______________________ Middle Name ______________________ Last Name ______________________

Preferred Name to be called (Nickname) ______________________________________ Age ___________ Sex ________

Date of Birth _______________ Marital Status _________ Social Security # _________________________________

Mailing Address __________________________________ Street Address ___________________________________

City ______________________________ State ________ Zip Code ____________ Home Phone (   ) ___________

Email Address: __________________________________ Referring Dr. ____

PATIENT'S EMPLOYMENT:

Employer ____ Occupation ________________________________

Employer Address ____

City _____________________ State ___________ Zip Code ____________ Work Phone (   ) ____________________

PATIENT'S SPOUSE:

Name ___________________________________Social Security # ___________________ Date of Birth _____________

Employer's Name ____ Work Phone (   ) _____________________

Employer's Address _________________________City _____________________ State _________ Zip Code _________

EMERGENCY INFORMATION:

Name of someone not living with you (in case of emergency).

Name ____ Phone (   ) __________________

Address ____ Relationship: ___________________

PERSON RESPONSIBLE FOR BILL:

Last Name _______________________________ First Name ______________________Middle Name ______________

Street Address ____

Mailing Address ____

City _____________________________________ State ________ Zip Code ________ Home Phone (   ) ____________

Social Security # ____ Date of Birth ____________

Employer's Name _____________________________________ Work Phone (   ) _____________, Extension ________

Employer's Address __________________________________ City _______________ State ________ Zip Code ________

PLEASE COMPLETE SECTION BELOW FOR WORKMAN'S COMP:

Date of Injury _______________________________

Whom should we contact to verify workman's comp? ____________________________ Phone (   ) _________________

FOR OFFICE USE ONLY

Date Verified ____________________________ Contact ___________________________ Phone (   ) _________________

Mail Claims to ____

Initial ______________

Over for Signature

INSURANCE AUTHORIZATION

INSURANCE AND/OR MEDIGAP ❑

I, the undersigned, authorize payment of medical benefits to this physician, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

DATE ______________________ SIGNED ____ *Lifetime Signature

MEDICARE ❑

I, the undersigned, understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any uncovered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made either to me or on my behalf to this physician for any services furnished me by the physician. I authorize any holder of medical information about me to release to The Healthcare Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

DATE ______________________ SIGNED ____ *Lifetime Signature

MEDICAID ❑

I agree to be responsible for any service not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this physician. I authorize any holder of medical or other information about me to release to the Division of Medicaid or its Fiscal Agent any information needed to determine these benefits payable for related services.

DATE ______________________ SIGNED ____ *Lifetime Signature

Hattiesburg Eye Clinic, P.A. and Hattiesburg Eye Clinic Cataract & Lasik Surgery Center, LLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ , do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

____ __________________________________

Signature of Patient or Authorized Representative **Date**

If authorized representative, relationship to patient: ____

____ __________________________________

Witness Signature **Date**

The following people (parent, spouse, family member, etc.) are <u>AUTHORIZED</u> to my medical records.

____ ____

Name Name

____ ____

Name Name

____ ____

Name Name