AESTHETIC EYE, PC

OCULOFACIAL PLASTIC &
RECONSTRUCTIVE SURGERY

Patient Registration

Patient Name:_____ **Date of Birth:** ___-___-____
First MI Last

Guardian:_____**Today's Date:**_____
First MI Last

Address:_____ **Age:**_____

City:_____ **State:**_____ **Zip:**_____

Home Phone:__(_____)_____ **Cell Phone:**__(_____)_____

Work Phone:__(_____)_____ **Email:**_____@_____

SS#: ____-____-_____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**_____ **Sex:** ☐ **Male** ☐ **Female**

Occupation: _____ ☐ **Retired** ☐ **Student**

Employer: _____ **Spouse's Name:** _____

Referring Physician:_____**Regular Eye Doctor:** ☐ **same as referring OR** _____

Primary Care Physician:_____

Emergency Contact:_____
Name Phone Relationship

May we leave a brief message on your home or cell phone? ☐ **Yes** ☐ **No**

May we leave an extended message on your home or cell phone? ☐ **Yes** ☐ **No**

May we leave a message for you at work to call us? ☐ **Yes** ☐ **No**

May we discuss your medical treatment with another person? ☐ **Yes** ☐ **No**

If yes, whom?_____ Relationship:_____

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Primary Insurance Company: _____**Policy/ ID #:**_____ **Group #:**_____

Policy Holder Name:_____ **Relationship to patient:**_____ **DOB:** _____

Secondary Insurance Company:_____ **Policy/ ID #:**_____ **Group #:**_____

Policy Holder Name: _____ **Relationship to patient:**_____ **DOB:**_____

Release of Information/ Financial Guarantee:

I give my permission to Aesthetic Eye, PC to bill my insurance company whether the benefits are to come to me or to Aesthetic Eye, PC. It is my understanding that I am eligible for medical benefits through my insurance. However, in the event that my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary", I agree to pay in full for all such charges. I fully understand that it is my responsibility to advise Aesthetic Eye, PC if my insurance requires pre-admission review, pre-admission authorization, or a second opinion, or if it contains any special provisions (to include exclusionary rider) which must be satisfied before payment by the insurance company can be made. If I fail to advise Aesthetic Eye, PC of such policy requirements and to comply in good faith, I agree to pay in full for all such charges. If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Doctor (co-pays will be made at time of service). I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Doctor.

The signature below authorizes direct assignment of benefits to Aesthetic Eye, PC.

Patient signature:_____ **Date:**_____

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND PICTURE ID TO THE FRONT DESK.