EYE SURGERY CENTER OF NORTHERN CALIFORNIA
PATIENT REGISTRATION

Surgeon's Name: _____

[ ]MR [ ]MRS [ ] MISS [ ]MS [ ]DR MARITAL STATUS: M S W D SEP SEX: M F

PATIENT NAME_____HOME PHONE_____
LAST FIRST M.I.

ADDRESS _____

CITY_____STATE_____ZIP_____

SS# _____/_____/_____ BIRTHDATE _____/_____/_____ AGE _____

CELL NO._____ E-MAIL ADDRESS_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____ WORK PHONE_____

NAME OF FAMILY DOCTOR_____PHONE NO._____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME_____RELATIONSHIP _____

PHONE (DAY)_____(EVE)_____

IF YOU HAVE INSURANCE CARDS PLEASE PERMIT US TO PHOTOCOPY THEM AS WELL AS A PHOTO ID

PRIMARY INS._____ ID#_____ GROUP# _____

SECONDARY INS._____ ID#_____ GROUP# _____

SUBSCRIBER (If other than patient) _____DOB_____

RELATIONSHIP TO SUBSCRIBER:_____

_____ (Initials) **I acknowledge that I have received the Notice of Privacy Practices.**

I HEREBY IRREVOCABLY AUTHORIZE MY INSURANCE COMPAY(S) OR FUND TO MAKE PAYMENT DIRECTLY TO **THE EYE SURGERY CENTER OF NOTHERN** CALIFORNIA OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, FOR SERVICES RENDERED TO DATE, BUT NOT TO EXCEED THE STATED CHARGES FOR THESE SERVICES. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY, AND FOR ANY CHARGES NOT PAID WITHIN SIXTY (60) DAYS OF BILLING TO INSURANCE COMPANY.** A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. I HEREBY AUTHORIZE **THE EYE SURGERY CENTER OF NORTHERN CALIFORNIA** TO FUNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CARE TO MY INSURANCE COMPANY(S). A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

SIGNATURE: PATIENT/LEGAL GUARDIAN_____DATE_____/_____/_____