Long Beach Eye Care
ASSOCIATES

# PATIENT REGISTRATION FORM

Appointment Date _____ Patient Name _____

Address: Street _____

City _____ State _____ Zip Code _____

❑ Male ❑ Female ❑ Single ❑ Married/Partnered ❑ Widowed ❑ Divorced ❑ Separated

Phone: Home _____ Work _____ Mobile _____

Age_____ Birthdate _____ Social Security # _____

Occupation _____ Driver's License # _____

Patient/Parent Employer _____

Employer's Address: Street _____

City _____ State _____ Zip Code _____

**Spouse/Partner**

Name _____ Occupation _____

Employer _____ Employer's phone _____

Employer's Address: Street _____

City _____ State _____ Zip Code _____

Person Responsible For Payment _____

Medicare# _____ Medi-Cal # _____

Medical Insurance _____ Group # _____

Subscriber _____ Id # _____

Vision Insurance _____ Group # _____

Subscriber _____ Id # _____

Referred by _____

I authorize treatment of the above named patient by a licensed physician or whom he/she may designate. I have received the notice of privacy practices. I agree to pay all charges shown by statements, promptly upon presentation. I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered.
I understand that I am financially responsible for any charges denied by my insurance company.

Signature _____ Date _____