PATIENT REGISTRATION SHEET

Patient (Mr., Mrs.)
Name (Miss, Ms.) _____
Address: _____
(City) _____ (State) _____ (Zip) _____
Home Phone: _____ Work Phone: _____ E-Mail: _____
Sex: ❑ M ❑F Cell Phone: _____
Date of Birth: _____ / _____ / _____ Social Security # _____ / _____ / _____
Referred by: (How did you hear about us?) _____
Patient's Family Physician: _____
Patient employed by: _____ Retired? ☐ Occupation _____
Address: _____
Spouse's Name: _____
Employed by: _____ Phone # _____
Emergency contact not living with you: _____ Relationship _____
Address: _____ Phone # _____
(City) _____ (State) _____ (Zip) _____
Insurance with: 1. _____ Policy # _____
2. _____ Policy # _____
Policy Holder Name _____ DOB: _____ SS# _____
Address: _____ Phone # _____
(City) _____ (State) _____ (Zip) _____

Authorization to Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to The Wright Eye Center when they accept assignment.

Authorization to Release Medical Information: I hereby authorize The Wright Eye Center to release any information necessary for my course of treatment and photocopies of this form are valid as the original.

Authorization of Responsibility: I understand I am ultimately responsible for services rendered even though I may be covered by medical, workman's compensation, or a private agreement with another party.

Notice of Privacy Practices: By my signature I acknowledge that I have received a copy the Notice of Privacy Practices from The Wright Eye Center/Natural Eyes Laser and Surgery Center.

SIGNATURE: _____ **DATE:** _____

JOHN R. WRIGHT, D.O.
BRANT R. GEHLER, O.D.
GEORGE L. ADAMS, O.D.
STEVEN P. CLANCY, O.D.

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