PATIENT REGISTRATION FORM
Great River Eye Clinic

Patient Name: ______________________

DOB: ______________________

Date: ________________

Address: ______________________________ City: ________________ State: ___ Zip: _________

Day Phone: ____________________________ Alternate Phone: ____________________________

E-mail: ________________________________

Date of Birth: ____/____/____ Sex: M F Social Security Number: ______________________

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Other ☐ Decline to Specify

Language: ☐ English ☐ Spanish ☐ Other ____________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Marital Status: Single Married Divorced Widowed Spouse's Name: ____________________________

Family Doctor: ____________________________ Clinic: ____________________________________

Referring Doctor: __________________________ Clinic: ____________________________________

Responsible Party *if* Minor: ____________________________________ Relationship: _____________

Responsible Party Date of Birth: ______/______/______ Social Security Number: ____________________

Friend or Relative Not at Your Address:

Name: ____ Phone: _____________________

Address: ________________________________ City: ________________ State: _____ Zip: __________

I authorize the release of any medical information necessary to process all claims.

Patient's Signature: ____ Date: __________________

I authorize the release of payment for medical benefits to my physician.

Patient's Signature: ____ Date: __________________

I request that payment of authorized Medicare benefits be made to me or on my behalf to S SJOBERG PLC for any services furnished to me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Patient's Signature: ____ Date: __________________