CENTER EYE CARE

162 Park Street Suite 201
North Reading, MA 01864
(978) 276-1111

Patient Registration Form

(Please Print)

Patient's Last Name:		First Name:		MI:
Date of Birth:	Age:	Sex: ☐ M ☐ F	Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	
Last 4 of SSN:		Occupation:		
Home Phone #:		Cell Phone #:		
Street Address:		City, State, and ZIP Code:		
Email Address:		Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mail		
Primary Care Physician:		Primary Care Physician's Address:		
Date of Last Eye Exam:		How did you hear about our office? ☐ Insurance Plan ☐ Sign on Building ☐ PCP ☐ Internet Search ☐ Family/Friend ☐ Other: ___________		

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Health Insurance Information

(Please give your insurance card to the receptionist)

Name of Insurance Company/Carrier:		
Person Responsible for Bill:		Address (if different):
Primary Phone Number:		Insurance Subscriber's Name:
Subscriber's DOB:	Subscriber's SSN:	Policy Number/ID:
Group Number:		Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: _________

Vision Insurance Information

(If Applicable)

Name of Vision Insurance Plan:		
Vision Insurance Subscriber's Name:	Subscriber's DOB:	Subscriber's SSN:
Policy Number/ID:	Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: _________	

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Insurance Policy

Thank you for choosing us to care for your vision and your eyes. Please provide us with your insurance card and any information we will need to access your insurance and to bill properly. **Up to date insurance information is required at the time of the visit.** If insurance information is not accurately disclosed, the patient will be responsible for any fees incurred. Professional fees are not refundable. All fees are ultimately the patient's responsibility. If you will need a referral for your visit, please obtain that referral before your visit or you will not be covered, and will be responsible for payment. **Understanding insurance benefits is ultimately the Insured's responsibility.** Anything not covered by insurance is the patient's responsibility.

I, ______________________________, have read, understand and agree to Center Eye Care's Insurance Policy.

Patient/Guardian Signature: ____ Date: ____________________

Assignment of Benefits

I request that payment of authorized assigned insurance be made directly to Dr. Suzanne M. Ward for any services rendered. I authorize this holder of medical information about me to release to CMS and agents and information to determine these benefits payable for related services.

Patient/Guardian Signature: ____ Date: ____________________

Notice of Privacy Practices

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Patient/Guardian Signature: ____ Date: ____________________

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Optomap Retinal Exam

The doctors at Center Eye Care have been using the Optomap Retinal Exam as part of our standard of care for the past several years. ***We have found this technology to be an invaluable tool***. This technology allows us to do a more thorough exam while at the same time providing a more comfortable experience for our patients. We have discovered retinal hemorrhages, glaucoma, melanoma, retinal holes, and other pathology all on seemingly healthy patients using this technology.

THIS IS AN ELECTIVE PROCEDURE.

The fee for this procedure is $39.

☐ I do **not** wish to have the Optomap Retinal Exam. By checking this box, I realize I will not be having the Optomap Retinal Exam and drops **will** be used to dilate my pupils as part of my comprehensive eye exam. Dilating drops may affect my vision and make driving and reading difficult.

☐ I **do** wish to have the Optomap Retinal Exam.

By checking this box, I realize am responsible for the $39 charge.

Patient/Guardian Signature: ____ Date: ____________________