Clarksville Eye Clinic | Registration

PATIENT INFORMATION

Full Name _____ Date of Birth _____
First Middle Last

Nickname _____ ❒ Male ❒ Female SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Preferred Language _____

Race ❑ American Indian or Alaskan ❑ Asian ❑ Black or African American ❑ Declined to Specify ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity ❑ Declined to Specify ❑ Hispanic or Latino ❑ Native Hawaiian/Other Pacific Islander ❑ Not Hispanic or Latino

Communication Preference ❑ Email ❑ Postal ❑ Telephone

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE ❑ Medical ❑ Vision

Insurance Name _____ ID Number _____

Name of Subscriber _____ Date of Birth _____

SSN _____ Relationship to Insured _____

Subsriber Address ❑ Same as Patient ❑ Different _____

Employer _____

SECONDARY INSURANCE ❑ Medical ❑ Vision

Insurance Name _____ ID Number _____

Name of Subscriber _____ Date of Birth _____

SSN _____ Relationship to Insured _____

Subsriber Address ❑ Same as Patient ❑ Different _____

Employer _____

PERMISSION TO TREAT

I give Clarksville Eye Clinic and its optometrists permission to examine, diagnose, and treat as necessary myself or the minor on this sheet.

SIGNATURE ON FILE AUTHORIZATION

I request and authorize that payments made by Medicare or other insurance companies be made to Clarksville Eye Clinic on my behalf for any services provided to me by Clarksville Eye Clinic or its optometrists.

RESPONSIBILITY STATEMENT

I further understand that I am responsible for the entire bill for services provided even though insurance has been filed on my behalf. Insurance is filed as a courtesy to our patients and every effort will be made to verify benefits prior to being seen. Insurance co—payments and/or deductible are due at time of service. I assume responsibility for all fees that are incurred if my account requires collections or an attorney.

RELEASE OF INFORMATION

I give permission to Clarksville Eye Clinic to release all medical and financial information related to the above individual to the following people:

1: _____ 2: _____

3: _____ 4: _____

PRIVACY POLICY

I have reviewed and been offered a copy of the privacy policies of Clarksville Eye Clinic.

Parent/Guardian Name (if under 18) _____

Signature (Parent or Guardian if under 18) _____ Date _____