Swartz Family Eyecare, LLC
Patient Registration Form
(please print)

A. PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:

_____

Patient's Date of Birth: Patient's SSN: Email Address:

_____

Address: City: State: Zip Code:

_____

Other immediate family members seen here: Phone: Cell or Home (circle one)

_____

B. BILLING/INSURANCE INFORMATION

Person responsible for bill: Date of Birth: Address (if different): Home phone (if diffe

_____

Is this person a patient here? Yes No Responsible Party's SSN:

_____

Name of Insurance holder: Date of Birth: Insurer's SSN:

_____

Name of Vision Insurance?

_____

C. ACKNOWLEDGEMENT OF RESPONSIBILITY

The information provided on my insurance card and provided above is true to the best of my knowledge. Wl making a third party claim, I authorize Swartz Family Eyecare, LLC to bill the insurance company on my be for any covered charges. I authorize the release of any medical information necessary for processing the clai also authorize my insurance company to pay insurance benefits on my behalf to Swartz Family Eyecare, LLC directly. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible pay the balance on my account for all professional services and materials provided.

_____ _____

Patient/Guardian Signature Date

D. ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have been offered the opportunity to review the Notice of Privacy Practices for Swartz Family Eyecare, LLC.

Family Eyecare, LLC.

_____

Patient Name (Please Print)

_____ _____

Patient/Guardian Signature Date

HIPAA rules prevent us from discussing protected health information with any person other than the patient, including family members of patients 18 years of age or older. If you would like to designate any individual that we are allowed to discuss your information with, please list below with contact information:

_____

_____

_____

_____

_____

_____