

**Registration :**

**Complete Eye Care Inc**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home Phone		How did you hear of us?		
Address 2			Work Phone				
			Cell Phone				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Phone	

<b>Pref Language:</b>	<b>Race:</b>	<b>Ethnicity:</b>	<b>County:</b>
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<b>Provider</b>	<b>Family Physician</b>	<b>Referring Physician</b>
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Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

**Policyholders/Guarantors (Person to be billed, if different than patient)**

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work Phone	Email:
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work Phone	Email:
City	State	Zip Code	Employer Name & Address			Occupation

**HIPAA Approved Contacts**

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work Phone
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work Phone

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to Complete Eye Care Inc , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

<b>Signature</b>	<b>Signature Date</b>	<b>Complete Eye Care Inc</b>	Phone: 314-395-9613
<b>X</b>		9890 Clayton Road, Suite 200	Email:
		Saint Louis, MO 63124	

**Please attach all pertinent insurance ID cards for photocopying.**