Patient Registration

Hudson River Eye Care **Today's Date: ______ / ______ / 2017**

PATIENT INFORMATION:

Full Name: ____ ( )Male ( )Female

Date of Birth: ______ / ______ / _____________ ( )Single ( )Married

Mailing Address: ____ **Work Phone**: ________________________

City: _____________________ **State**: _______ **Zip**: _____________ **Home Phone**: ________________________

Email: ____ **Cell Phone**: ________________________
(for contact purposes only)

Social Security #: ______________________________ **Parent/Guardian: ____________________________**
(if patient under 18)

Primary Doctors Info: ____________________________ **Pharmacy Info:_______________________________**

INSURANCE INFORMATION:

Policy Holder: ( ) **Self** *(same info as above)*

( ) **Parent** ( ) **Spouse**	Full Name____ ( ) Male ( ) Female / ( ) Single ( ) Married

Ins. Company: ____________________________ **Member Date of Birth**: _______ / _______ / _______________
(if different from above)

Ins. ID#: _________________________________ **Member Social Security #: __________________________**
(if different from above)

NOTICE OF PRIVACY PRACTICES:
I have received, read, and understand the *Notice of Privacy Practices* regarding my protected health information.

I have read and understand the above policy: ___________________________________ ______ /______ / 2017
Patient Signature (or Guardian if patient is under 18) **Date**

INSURANCE AUTHORIZATION ASSIGNMENTS OF BENEFITS:
I hereby authorize Hudson River Eye Care to furnish insurance carriers any information concerning my condition and treatments and I hereby assign them all payment for services rendered to my dependents or myself. I understand that I am responsible for the amount not covered by my insurance.

I have read and understand the above policy: ___________________________________ ______ /______ / 2017
Patient Signature (or Guardian if patient is under 18) **Date**