

Patient Registration

Hudson River Eye Care

Today's Date: ____ / ____ / 2021

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	Full Name _____
() Spouse	() 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: _____ / ____ / 2021
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: _____ / ____ / 2021
Patient Signature (or Guardian if patient is under 18) _____ Date