

PATIENT REGISTRATION

Welcome to Melamed Eye Care!

Thank you for choosing our office for your eye care. In order to provide you the best care possible, we ask that you answer the questions on this and the following pages.

1. PATIENT INFORMATION				DATE:
PATIENT'S NAME: LAST		FIRST	M.I.	
HOME STREET ADDRESS		CITY	STATE	ZIP
DAYTIME PHONE / WORK ()		HOME ()		
OCCUPATION		CELL ()		
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> MINOR	SOCIAL SECURITY (last 4 only) _ _ _ _
E-MAIL	DATE OF BIRTH	AGE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE

2. INSURANCE	
VISION INSURANCE	MEDICAL / OTHER INSURANCE (PPO Only)
INSURANCE COMPANY	INSURANCE COMPANY
ID#	ID#
PRIMARY CARDHOLDER	SUPPLEMENT INS. (if any)
PRIMARY'S SSN#	PRIMARY CARDHOLDER NAME
PRIMARY'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
RELATIONSHIP TO PATIENT	PRIMARY'S DATE OF BIRTH
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage as described above and assign directly to Fouad Melamed, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all 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 insurance submissions.

Patient/Guardian Signature: _____ **Date:** _____

If Minor, Print full name of Parent or Guardian: _____

3. PRIVACY PRACTICES
I acknowledge that I have read and fully understand the Notice of Privacy Practices given to me with this form.
Patient/Guardian Signature: _____ Date: _____

4. PLEASE LET US KNOW
HOW DID YOU FIND US? <input type="checkbox"/> GOOGLE <input type="checkbox"/> YELP <input type="checkbox"/> VSP <input type="checkbox"/> EYEMED <input type="checkbox"/> ANTHEM <input type="checkbox"/> BLUE SHIELD <input type="checkbox"/> UNITEDHEALTHCARE
<input type="checkbox"/> OTHER _____ <input type="checkbox"/> REFERRAL WHOM MAY WE THANK FOR REFERRING YOU? _____