Registration : Southside Eye Care PLLC

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Phone

Pref Language:	Race:	Ethnicity:	County:

Provider	Family Physician	Referring Physician

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

HIPAA Approved Contacts are individuals we may release your relevant health information to.
Do you have Medicare benefits? Yes No
Are you younger than 65 and disabled? Yes No
If married, is your spouse currently employed with medical insurance benefits? Yes No N/A

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Southside Eye Care PLLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financiallly 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 my insurance submissions. I understand that payment is expected at the timeof 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.

Signature	Signature Date	Southside Eye Care PLLC
X		3206 Churchland Blvd Chesapeake, VA 23321 Phone: 757-484-0101 Email:

Please attach all pertinent insurance ID cards for photocopying.