

**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              |                | 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             |
| 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 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 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.

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

Please attach all pertinent insurance ID cards for photocopying.