metro eye MD

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	,
Address:	Relationship to patient: _____
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( ) _____ - _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone: ( ) _____ - _____
Patient email:	

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)	Policy Information
Last Name:	Patient's relationship to policy holder:
First Name:	ID/Certification No.:
Middle Name:	Policy/Group No.:
Address:	
City: State: Zip:	
Date of Birth: Sex (please circle): **M** or **F**	
Employer Name:	

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)	Policy Information
Last Name:	Patient's relationship to policy holder:
First Name:	ID/Certification No.:
Middle Name:	Policy/Group No.:
Address:	
City: State: Zip:	
Date of Birth:, Sex (please circle): **M** or **F**	
Employer Name:	

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed _____ **Date:** _____