Registration : Summit Eye Center, PC

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

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

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

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	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:

IF YOU HAVE A CELL # ON FILE- YOU WILL RECEIVE TEXT REMINDER MESSAGES FOR UP COMING APPOINTMENTS
IF YOU HAVE A LAND LINE- YOU WILL RECEIVE VOICE REMINDERS
IF YOU HAVE AN EMAIL ON FILE- YOU WILL RECEIVE AN EMAIL REMINDER
Please let us know if you chose to NOT receive one of these.

Patient's or Authorized Person's Signature

I, the undersigned, give my authorization to treat and assign directly to Summit Eye Center, PC, all medical benefits, if any, otherwise payable to mefor services rendered. I understand that I am ultimately financially respsonsible for all approved and covered charges whether or not paid by my 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 practices 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
X	

Summit Eye Center, PC
3650 E. 15th St.
Loveland, CO 80538
Phone: 970-669-1107
Email:

Please attach all pertinent insurance ID cards for photocopying.