



OFFICE USE ONLY	
ACCOUNT NO./MR NO.	
DOCTOR NO.	OFFICE NO.
REVIEWED BY	

**PATIENT REGISTRATION (PLEASE PRINT)**

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
FIRST MI LAST

PATIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENT HOME PH. NO. \_\_\_\_\_ PATIENT CELL PH. NO. \_\_\_\_\_ EMAIL \_\_\_\_\_

SEX:  MALE  FEMALE RELATION TO RESPONSIBLE PARTY  WIFE  HUSBAND  CHILD  OTHER, SPECIFY \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_ WORK PHONE NO. \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
FIRST MI LAST

REFERRING PHYSICIAN \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
FIRST MI LAST

OPTOMETRIST \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
FIRST MI LAST

EMERGENCY (NAME) \_\_\_\_\_ RELATION \_\_\_\_\_ CONTACT (PHONE NO.) \_\_\_\_\_

WHO MAY WE DISCLOSE YOUR HEALTH INFORMATION TO: \_\_\_\_\_ RELATION \_\_\_\_\_

HAS ANY IMMEDIATE FAMILY MEMBER BEEN SEEN BY EYE ASSOCIATES?  YES  NO

IF YES, NAME OF FAMILY MEMBER AND RELATIONSHIP \_\_\_\_\_

IS THIS A WORKER'S COMPENSATION CLAIM?  YES  NO DATE OF INJURY \_\_\_\_\_

**(GUARANTOR) RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT**

NAME \_\_\_\_\_  MALE  FEMALE RELATIONSHIP TO PATIENT \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE NO. \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ WORK NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

**INSURANCE COMPANY INFORMATION**

PRIMARY INSURANCE CO. \_\_\_\_\_ SECONDARY INSURANCE CO. \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

INS. ID NO. \_\_\_\_\_ INS. ID NO. \_\_\_\_\_

GROUP NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_

POLICY HOLDER DOB \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

REL. TO HOLDER \_\_\_\_\_ REL. TO HOLDER \_\_\_\_\_

**PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION / RESPONSIBLE PARTY STATEMENT**

I, the undersigned, authorize payment of benefits as determined by the Company, directly to Eye Associates of New Mexico. I authorize Eye Associates of New Mexico to release any information requested, including medical information, to any insurance company, employer, third party payer, third party administrator for purposes of processing my claims. As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance, and/or deductibles in accordance with the terms and conditions of my health insurance policy.

**X** \_\_\_\_\_  
 PATIENT SIGNATURE DATE

**X** \_\_\_\_\_  
 RESPONSIBLE PARTY SIGNATURE DATE