Eye Associates of New Mexico eyenm.com

REGISTRATION INFORMATION

NextGen #
Date:
FOR OFFICE USE ONLY Updated By:
Rev.1/15

PATIENT DEMOGRAPHIC INFORMATION

Date ____________________

Last Name ______________________ First Name ______________________ M.I.____ Gender: M__ F__

SSN (optional) ______________________ Last 4 Digits (requested) ____________ Birth Date ____________

Patient Mailing Address ____

City ____ State ________________ Zip Code ____________

Home Phone ______________________ Day ______________________ Cell Phone ______________________

Emergency Contact ________________________________ Phone ______________________________

Whom may we disclose your health information to? __________________________ Relation ______________

Employer ________________________ Occupation ______________________________________

Do you have a Power of Attorney? ☐ Y ☐ N If yes, Name ____________________ Phone ______________

Race: ☐ Asian ☐ African American ☐ Multi-racial ☐ Native American ☐ White ☐ Other Race ☐ Not Reported

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Not Reported

Primary Language: ____________________________ *Email Address ______________________________

*Your e-mail address will not be disclosed to any other party and you may opt out of future e-mail communications by notifying the receptionist.

What is Your Preferred Method of Contact ☐ Telephone ☐ Mail ☐ Email

INSURANCE INFORMATION

Primary Insurance Name ______________________________ Policy Holder ID ______________________

Secondary Insurance Name ____________________________ Policy Holder ID ______________________

Do you have a vision plan? ☐ Y ☐ N If yes, name of vision plan? ______________________________

Primary Care Physician ________________ Referring Physician ______________ Optometrist ____________

Is this a worker's compensation claim? ☐ Y ☐ N If yes, date of injury? ______________________________

CONSENT TO TREAT

I hereby consent to treatment including tests, procedures and medications directed by Eye Associates of New Mexico providers.

NOTICE OF PRIVACY PRACTICES

I have had an opportunity to receive and review my notice of privacy practices. ☐ Patient was unable to sign.

PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION

I, the undersigned, authorize payment of benefits as determined by the Insurance 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.

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance, and/or deductibles and noncovered services in accordance with the terms and conditions of my health insurance policy.

Responsible Party ________________________ Signature ____________________ Relationship to Patient _____
(please print name)

Patient/Responsible Signature ____ Date ______________