Eye Associates of New Mexico eyenm.com

REGISTRATION INFORMATION

PATIENT DEMOGRAPHIC INFORMATION

Date _____

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

SSN _____ Birth Date _____

Patient Mailing Address _____

City _____ State _____ Zip Code _____

*Email Address _____ Primary Language _____

Home Phone _____ Day Phone _____

Cell Phone _____ OK to text appointment reminders to this number? ☐Yes ☐No

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

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

*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.

INSURANCE INFORMATION

Primary insurance _____ Secondary insurance _____

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 _____

FOR OFFICE USE ONLY Updated By: _____ Date: _____ NextGen # _____

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