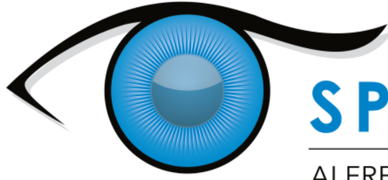

SPECIALIZED EYE CARE

ALFRED KRONTHAL, MD • BRETT LEVINSON, MD • STAN BRULL, MD
1 VILLAGE SQUARE, SUITE 190, BALTIMORE, MD 21210
PHONE: 410.435.8881 • **FAX:** 410.435.8886

PATIENT REGISTRATION FORM

To Our Patients: Certain information requested is mandated by the government.

PATIENT NAME (*Last, First, MI*): ____________________ NICKNAME__________

SOCIAL SECURITY # ________-________-__________ **DATE OF BIRTH** _____/_____/____SEX______________

ADDRESS____ZIP CODE___________

HOME # ____________________**WORK #** ____________________**CELL #** __________________________

EMAIL ADDRESS ____________________________ **MARITAL STATUS**__________________________

EMPLOYER ____

RACE ____**CAUCASIAN/WHITE**____**BLACK/AFRICAN AMERICAN** ____**ASIAN** ____**MULTI-RACIAL**

____**AMERICAN INDIAN** ___**ALSAKAN NATIVE** ___**NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER**

ETHNICITY ____**SPANISH/LATINO** ____**NON HISPANIC** ____**OTHER** (*Please Specify*) __________________

HOW DID YOU HEAR ABOUT SPECIALIZED EYE CARE?______________________________________

REFERRING PHYSICIAN__________________________________**TELEPHONE**____________________

PRIMARY PHYSICIAN____________________________________**TELEPHONE**____________________

EMERGENCY CONTACT __________________________________**TELEPHONE**____________________

(*Please provide number other than patient's number*)

RELATIONSHIP TO PATIENT____

PHARMACY NAME/LOCATION______________________________**TELEPHONE**____________________

<u>INSURANCE INFORMATION</u>

PRIMARY INSURANCE ________________________**POLICY HOLDER DOB** ________________________

POLICY HOLDER______________________________**RELATIONSHIP TO PATIENT** __________________

POLICY NUMBER______________________________**GROUP NUMBER**______________________________

SECONDARY INSURANCE________________________**POLICY HOLDER DOB**__________________________

POLICY HOLDER______________________________**RELATIONSHIP TO PATIENT** __________________

POLICY NUMBER______________________________**GROUP NUMBER**______________________________

GUARANTOR'S NAME AND ADDRESS IF OTHER THAN PATIENT________________________________

____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I herby authorize treatment and authorize Specialized Eye Care to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance. I certify that all the information I have reported above is correct. I permit a copy of this authorization to be used in place of the original and kept on file for life. Either the above named carrier(s) or I may revoke this authorization at anytime in writing.

SIGNATURE____**DATE**______________________________________