

2009 Patient Registration Form

Please Fill Out Completely

HIPAA COMPLIANT

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Title: Mr. Miss Mrs. Sex: Male Female
Birth Date: _____ Social Security Number: _____ Smoker: No Yes
Patient Address: _____ City: _____
State: _____ Zip: _____ Home Phone: (____) _____ Cell Phone: (____) _____
Employer: _____ Work Phone: (____) _____ Email: _____
Reason for Today's Visit: _____
Previous Eye Surgery: No Yes What Type: _____ Physician: _____ Year: _____
Primary Care Physician: _____ Physician's Phone: (____) _____
Other physician(s) who care(s) for you and to whom we may disclose information regarding your care:
Physician(s): _____, _____ Physician(s) Phone: (____) _____, (____) _____
Pharmacy Name: _____ Pharmacy Address: _____
City: _____ State: _____ Zip: _____ Pharmacy Phone: (____) _____
Emergency Contact: _____ Phone: (____) _____
What encouraged you to see Dr. Abell: Radio Station _____ Newspaper _____
 Internet Site _____ Referred by: _____ Other: _____

SECTION 2: INSURED CARDHOLDER OR OTHER FINANCIALLY RESPONSIBLE PERSON

Same as Above (if NOT same as above, please complete this section)
Responsible Party Name: _____ Birth Date: _____
Social Security Number: _____ Relationship to Patient: _____
Insured Address: _____ City: _____
State: _____ Zip: _____ Home Phone: (____) _____ Cell Phone: (____) _____
Employer: _____ Work Phone: (____) _____

SECTION 3: INSURANCE INFORMATION (Cards Must Be Presented To Front Desk)

Primary Insurance

Insurance Company: _____
Address: _____
City: _____ State: _____
Zip: _____
Subscriber Name: _____
Subscriber ID#: _____
Group or Policy ID#: _____
Subscriber Employer: _____

Secondary Insurance

Insurance Company: _____
Address: _____
City: _____ State: _____
Zip: _____
Subscriber Name: _____
Subscriber ID#: _____
Group or Policy ID#: _____
Subscriber Employer: _____

PLEASE PRESENT INSURANCE CARD(S) TO FRONT DESK FOR COPYING

▶▶▶ Please read, sign, and date the Patient Privacy and Payment Agreements on the back. ▶▶▶