# New Patient Registration

Mr Ms

^^ ***Patient***'s Last Name ^^ First Name Middle Initial Sex Date Of Birth

Address City State Zip Social Security No.

Single, Married, Divorced, Widowed

Home Phone Alternate Phone (cell, work) Marital Status

## Responsible Party

Name Home Phone Work Phone

Address City State Zip

## Insurance

***Primary*** Insurance Name Number Effective Date

Subscriber Name Relationship

Subscriber Birthdate Subscriber Social Security Number

***Secondary*** Insurance Name Number Effective Date

Subscriber Name Relationship

Subscriber Birthdate Subscriber Social Security Number

## Emergency Contact

First Name MI Last Name Phone Relation

Address City State Zip

### INSURANCE AUTHORIZATION, ASSIGNMENT AND REFERRAL

I consent to treatment necessary for the care of the above-named patient. If registering a minor, I certify that I am the child's custodial parent or legal guardian. I authorize Ophthalmic Consultants of Tidewater (OCT) to furnish information, generate referral letters and release all medical records to the referring and personal physicians and to my insurance carriers including the Social Security Administration or its intermediaries, concerning my illness and treatment. I permit fax and electronic transmittal of my medical records. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment. I understand that insurance is a contract between me and my insurance company and that any filing of insurance by OCT is a courtesy only. I am fully responsible for obtaining and delivering any applicable referrals. I authorize and request that insurance payments be made directly to OCT should they elect to receive such payments.

I understand that payment of all charges incurred is due at the time of service. I acknowledge full financial responsibility for services rendered by OCT. I understand that I am financially responsible for any outstanding balances. In the event of default on any payment due, I agree to pay all costs of collection, including attorney fees of 30% on the amount due at the time of default. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date Signature rev 062814