Eye Surgery Associates
Diplomates, American Board of Ophthalmology

- 300 South Park Rd, Suite 300, Hollywood, FL 33020 Tel: (954) 925-2740
- 603 N. Flamingo Road, Suite 250, Pembroke Pines, FL 33028 Tel: (954) 431-2777
- 2300 N. Commerce Pkwy, Suite 307, Weston, FL 33326 Tel: (954) 217-3155

PATIENT REGISTRATION **DATE** _____

First Name:	Last Name:		Phone Numbers: Home: Work: Cell:
Address:		Apt Number:	
City:	State:	Zip Code:	Social Security #:
Email Address:		Marital Status: Single ( ) Married ( ) Divorced ( ) Widow ( )	
Sex: Male ( ) Female ( )	Age:	DOB:	Race/ Ethnicity:
Occupation: (former if retired)	Employer:		
Employer Address:	City:	State:	Zip:
Referred By: PCP ( ) Optometrist ( ) Friend ( ) Relative ( ) Other: ( )	List Full Name and Phone number for Referring Doctor:		

INSURANCE INFORMATION:

Primary Insurance Company Name:		Primary Subscriber Name: DOB: Social Security #:
Policy (ID)Number:	Group #	Relationship to Patient: Self ( ) Spouse ( ) Parent ( )
Insurance Address:		Insurance Telephone number:
Secondary Insurance Company Name:		Primary Subscriber Name: DOB: Social Security #:
Secondary Policy Number:	Group #	Relationship to Patient: Self ( ) Spouse ( ) Parent ( )
Insurance Address:		Insurance Telephone number:

Physician's Release and Assignment: I authorize the release of Medical and other information necessary to process and receive payment on health insurance claims. I also request payment of benefits be made to my Provider. A copy of this authorization may be used in lieu of the original.

Financial Agreement: I understand that I am financially responsible for any charges incurred for services provided. If I have health insurance coverage and my provider is in network, I understand that I'm financially responsible for all co-payments, deductibles, and co-insurance associated with covered services. If I have out of network benefits and my provider is out of network, I understand that I will be responsible for higher co-insurance, deductibles, and co-payments. If I choose to have non-covered services performed, I will be responsible for the full payment of those charges. Outstanding patient balances over 60 days will incur a charge at the highest rate allowed by law. If my account is sent to collections for lack of payment I agree to pay my provider's fees and expenses incurred in collecting any such amounts, including without limitation, attorney's fees and costs.

I hereby consent to receive marketing materials from Provider from time to time.

Patient's / Guardian Signature _____