

CENTRAL VALLEY EYE MEDICAL GROUP, INC
PATIENT REGISTRATION

Referred by: _____ **Family doctor:** _____

Patient Name. _____ Today's Date _____
Last First Middle

Home Address _____
City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____
E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Central Valley Eye Medical Group to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patient's signature

Today's date