

# REGISTRATION FORM

(Please Print)

## PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		Email Address:		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:			Home phone no.: ( )			
City		State:		Zipcode:		Employer Phone no.: ( )			
Occupation:		Employer:			Cell phone no.: ( )				
Chose clinic because/referred to clinic by (Please check one box): <input type="checkbox"/> Dr.					<input type="checkbox"/> Insurance plan		<input type="checkbox"/> Friend		
<input type="checkbox"/> Family	<input type="checkbox"/> Previous Patient	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other				
Other family members seen here:									

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance (if yes, please check all that apply)		<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> BCBS	<input type="checkbox"/> United Health Care	<input type="checkbox"/> Cigna	
<input type="checkbox"/> Vision Service Plan (VSP)	<input type="checkbox"/> Eyemed	<input type="checkbox"/> Superior Vision	<input type="checkbox"/> AETNA		<input type="checkbox"/> Other _____		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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## NOTICE OF PRIVACY PRACTICES

Please contact Sharon Harris at 919 881 0900 if you have any questions about our notice of privacy practices

**\*I hereby acknowledge that I have reviewed a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.\***

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Triangle Eye Institute or my insurance company to release any information required to process my claims.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I \_\_\_\_\_ authorize \_\_\_\_\_ to release my healthcare information to Triangle Eye Institute OD PA  
(Patients Name ) (Name of previous eye doctor or clinic )

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

