ReFocus
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Patient Registration

Date _____

Patient Name Last : _____ First: _____ Middle _____

☐ Male ☐ Female ☐ Mr ☐ Mrs ☐ Miss ☐ Master

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Date of Birth: ____/____/____ Age: _____ Social Security _____

Race: ☐ White ☐ Black ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

Religion: ☐ Catholic ☐ Jewish ☐ Other _____

Email Address: _____

Preferred Pharmacy: _____

Responsible Party (or guardian) Name: _____

Relationship to patient: _____ Phone number: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____ Address: _____

Referred By: Who may we thank for your visit today? _____

Primary Care Physician: _____ Phone number: ( ) _____

Emergency Contact: _____ Phone number: ( ) _____

Relationship to Patient: _____

Does your plan require referrals for specialist care? ☐ Yes ☐ No

Primary Insurance: _____

Policy # _____ Group# / Name _____ Copay $ _____

Policyholder Name _____ Social Security # _____

Date of Birth: ____/____/____ Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance: _____

Policy # _____ Group# / Name _____ Copay $ _____

Policyholder Name _____ Social Security # _____ _____

Date of Birth: ____/____/____ Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child

Please turn page over for insurance payment disclosure & signature

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Insurance Payment Disclosure & Signature

I authorize ReFocus Eye Health to receive all insurance payments from my current medical insurance plan.

I agree to pay applicable co-payments, deductibles and non-covered fees. I will pay my deductible and non-covered services upon first notification.

I agree to pay applicable co- payments at the time of service.

If my plan requires a prior approval or referral, I accept responsibility for all payments for non- approved and/or non-referred charges.

I agree to release all information necessary for my current insurance plan to process my claims.

I agree to pay in full at the time of service if I do not have insurance or choose not to have my insurance filed by your office.

I hereby acknowledge that I have received a copy of ReFocus Eye Health's "Notice of Privacy Practice." I understand that if I have any questions or complaints regarding my privacy rights that I may contact the Privacy Officer for ReFocus Eye Health. I further understand that the practice will offer me updates to this notice should the notice change in any way.

I understand and agree with the above authorization and statements.

x _____ _____

Print Name of Patient or Representative / Parent or Guardian of Minor Child (If not the insured) Date

x _____ _____

Signature of Patient or Representative / Parent or Guardian or Minor Child Date

☐ Patient refused to sign

☐ Patient unable to sign reason: _____