OPHTHALMIC PLASTIC & ORBITAL CONSULTANTS, P.C.
THE CENTER FOR EYELID AND FACIAL PLASTIC SURGERY, LLC.

PATIENT REGISTRATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

ADDRESS: _____

_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____

STATUS: *Married* *Single* *Divorced* *Widowed* GENDER: *Male* *Female*

EMPLOYER: _____ JOB TITLE: _____

WORK ADDRESS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

OTHER PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

ID NUMBER: _____ GROUP NUMBER; _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

ID NUMBER: _____ GROUP NUMBER; _____

I request that payment of authorized benefits (including Medicare) be made on my behalf to Kevin I. Perman, M.D., Albert S. Cytryn, M.D. or The Center for Eyelid and Facial Plastic Surgery, LLC. for any services furnished to me by physician or supplier. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I further understand that I will be responsible for any additional charges that are incurred on my behalf (including bank charges, attorney fees and collection fees.)

I hearby authorize said assignee to release all information necessary to secure this payment.

SIGNATURE: _____ **DATE:** _____

For office use

Entered and verified by: _____ *Date:* _____	**All of the information above is correct / No changes**
Entered and verified by: _____ *Date:* _____	Signature: _____ Date: _____
Entered and verified by: _____ *Date:* _____	Signature: _____ Date: _____