PATIENT REGISTRATION FORM

Please fill out form completely

PLEASE PRINT

Name of Patient____
First Middle Last

Address ___________________________________City _______________

State________________Zip Code_____ Date of Birth __________Age ________

Cell#_______________Home#_______________Work#_______________

Email Address ____

Mr/ Mrs /Miss /Ms /PhD/ Dr (other) _________ Social Security# _______________

Occupation________________Employer______________________________

Have we seen other family members, list name/relationship_______________________

Name of Spouse_______________Occupation_________________________

Parent's name if minor____

Responsible Party's Name (if patient is a minor) ___________________________

Responsible Party's Address ____

Physician you are seeing today **John H Wood, MD** * **David R Haas, MD**

How did you hear about us? Internet Newspaper Advertisement Telephone book
Friend / Relative:____________ Referred by Doctor__________ Other________

Insurance Information

Please Provide A Current Copy of Your Insurance Card to Front Desk. **We Will NOT Be Able To Honor Your Insurance If You Do Not Have A Current Copy Of Your Card.**

All co-pays are to be paid at the time of your visit. If this is an issue, you should speak with the front desk before being seen by the doctor.

Payment Will Be Expected At The Time of The Visit – Including Vision/Medical Coverage Co-Pyament(s).

If you want/wear contact lenses, please be advised that most Insurance Companies will not cover that part of the exam and you will pay separately for that service.

Authorization to pay benefits to Physician/Authorization to release medical information

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO CHAPEL HILL OPHTHALMOLOGY CLINIC, P.A. SHOULD THE DOCTOR AGREE TO ACCEPT ASSIGNMENT I AUTHORIZE CHAPEL HILL OPHTHALMOLOGY CLINIC, P.A. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY CLAIM(S) OR RELATED SERVICES.

SIGNED ___________________________________DATE _______________