Honolulu Eye Clinic

Patient Registration Form

Patient information - please print	Visit information
Patient Last name_____ First name_____ Initial____ Street address: _____Title:_____ City: _____ St: ___ Zip: _____ Date of birth: ____/____/____ Gender: ☐ Female ☐ Male Home phone: _____Cell: _____Social Security#: _____-____-_____ Email: _____	Date of visit: ____/____/____ ☐ 1st visit - new patient ☐ Return visit - former patient with updated information For office use only: PC Doctor: ☐JW ☐RW ☐JB ☐ ____

Family Physician (or Pediatrician):	Whom may we thank for sending you to our clinic?
Mailing Address:_____ Phone:_____ Fax:_____ Email:_____	☐ Referred by another doctor:_____ ☐ Referred by patient ☐ Referred by friend ☐ Yellow Page Ad ☐ Newspaper Ad ☐ TV Ad ☐ Radio Ad Other:_____
Name of Parent/Guardian #1:	**Name of Parent/Guardian #2:**
Name:_____ Daytime Phone:_____ Employer:_____Cell Phone:_____ Occupation:_____Email:_____	Name:_____ Daytime Phone:_____ Employer:_____Cell Phone:_____ Occupation:_____Email:_____

Health Insurance information

	Insurance Company	Subscriber Name	Relation	Subscriber #	Subscriber Birthdate
Primary	_____	_____	_____	_____	____/____/____
Secondary	_____	_____	_____	_____	____/____/____
Other	_____	_____	_____	_____	____/____/____

If Workers Comp - please fill out additional form available from check-in desk.

Financial and insurance information – PLEASE READ CAREFULLY

- Please present ALL insurance cards to the receptionist so that we may make copies for our files.
- We participate with many insurance carriers and file your insurance claims. However, should your visit be denied by your insurance company, you will be responsible for the balance on your account. Payment in full is expected upon notification.
- If you do not have insurance or if you have an insurance plan for which we do not participate you must pay in full for your services before leaving the clinic. You are responsible for the costs of any products and services you receive from the clinic.
- All contact lenses and glasses purchased through this office must be paid for in full prior to dispensing
- **Medicare and HMSA 65C+** limits the number of services or visits for which they will pay. It does not cover routine eye examinations and any part of the exam that includes "refraction". If Medicare will not cover your visits you are responsible for payment for them.

SIGNATURE REQUIRED - Please read carefully and sign below

- All insurance claims filed by this office for me require my signature. By signing below I authorize the Honolulu Eye Clinic and its physicians to submit claims for benefits without obtaining my signature on each and every claim submitted for myself or my dependents and that I will be bound by this signature as though I had personally signed the particular claim.
- In the event that a collection agency or attorney has to be used to collect the amounts I owe the Honolulu Eye Clinic I agree that I will be responsible for all costs incurred to collect from me using those services.
- I have received a Patient Privacy Statement from the Honolulu Eye Clinic.

Parent/Guardian (or Patient) Signature_____**Date:**_____/_____/_____ Form Update: APM 8/1/08

Submit