Honolulu Eye Clinic

Patient Registration Form

Patient Information - Please Print

Last: _____ First: _____ Middle:_____ Title:_____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Gender: ☐F ☐M Marital status: _____ Drivers Lic#_____

Primary Phone Number: _____ circle one: ☐Home ☐Cell ☐Work

Secondary Phone Number: _____ circle one: ☐Home ☐Cell ☐Work

Email: _____ SSN: _____

Employment of Patient (or guardian)

Employer:_____

Occupation:_____

Work phone:_____

Primary Care Physician

Full Name:_____

Phone:_____

Address:_____

Spouse (or emergency contact) Information

Name_____ SSN: _____

Employer:_____DOB:_____

Occupation:_____Work Phone:_____

Whom may we thank for sending you to our clinic?

Referred by Dr._____

Referred by: ☐Patient ☐Friend ☐Yellow Pages ☐Internet

☐Newspaper Ad ☐TV Ad ☐Radio Ad Other:_____

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 exams and any part of the exam that includes "refraction". If Medicare will not cover your visits you are responsible for payment.

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.

Patient (or Guardian's) Signature_____Date:_____/_____/_____

REV 4/09

Submit