

**Registration :**

|      |            |          |          |              |
|------|------------|----------|----------|--------------|
| Date | Account ID | Chart ID | Other ID | Internal Use |
|------|------------|----------|----------|--------------|

**Patient Information**

|                   |            |          |                         |                |                         |                |                   |
|-------------------|------------|----------|-------------------------|----------------|-------------------------|----------------|-------------------|
| Last Name         | First Name | Middle   | Gender                  | Marital Status | Birthdate               | Age            | Social Security # |
| Address           |            |          | Home:                   |                | How did you hear of us? |                |                   |
| Address 2         |            |          | Work:                   |                |                         |                |                   |
|                   |            |          | Cell:                   |                |                         |                |                   |
|                   |            |          | Email:                  |                |                         |                |                   |
| City              | State      | Zip Code | Employer Name & Address |                |                         | Occupation     |                   |
| Emergency Contact |            | Phone    | Pharmacy                |                |                         | Pharmacy Phone |                   |

|                  |                         |                            |
|------------------|-------------------------|----------------------------|
| <b>Physician</b> | <b>Family Physician</b> | <b>Referring Physician</b> |
|------------------|-------------------------|----------------------------|

| Medical Insurance | Name & Address | Policyholder | Relationship | Policy ID | Group ID |
|-------------------|----------------|--------------|--------------|-----------|----------|
| 1                 |                |              |              |           |          |
| 2                 |                |              |              |           |          |
| 3                 |                |              |              |           |          |

**Guarantor (Person to be billed, if different than patient)**

|             |            |          |                         |                |           |                   |
|-------------|------------|----------|-------------------------|----------------|-----------|-------------------|
| 1 Last Name | First Name | Middle   | Gender                  | Marital Status | Birthdate | Social Security # |
| Address     |            |          | Home:                   |                | Work:     | Email:            |
| City        | State      | Zip Code | Employer Name & Address |                |           | Occupation        |
| 2 Last Name | First Name | Middle   | Gender                  | Marital Status | Birthdate | Social Security # |
| Address     |            |          | Home:                   |                | Work:     | Email:            |
| City        | State      | Zip Code | Employer Name & Address |                |           | Occupation        |

**HIPAA Approved Contacts**

|             |            |        |        |           |                   |              |
|-------------|------------|--------|--------|-----------|-------------------|--------------|
| 1 Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
| Address     |            | City   | State  | Zip Code  | Home:             | Cell:        |
|             |            |        |        |           |                   | Work:        |
| 2 Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
| Address     |            | City   | State  | Zip Code  | Home:             | Cell:        |
|             |            |        |        |           |                   | Work:        |

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to Eye Care Arkansas, P A , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

|           |                |                               |                     |
|-----------|----------------|-------------------------------|---------------------|
| Signature | Signature Date | <b>Eye Care Arkansas, P A</b> | Phone: 501-225-4488 |
| <b>X</b>  |                | 9800 Lile Drive, Suite 301    |                     |
|           |                | Little Rock, AR 72205         | Email:              |

**Please attach all pertinent insurance ID cards for photocopying.**