Registration :

Coventry Eye Associates, P.C.

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address

Address 2

Home:

Work:

Cell:

Email:

How did you hear of us?

City | State | Zip Code | Employer Name & Address | Occupation

Emergency Contact | Phone | Pharmacy | Pharmacy Phone

Physician

Family Physician | **Referring Physician**

Medical Insurance

	Name & Address	Policyholder	Relationship	Copay	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:

Check ____ if all family members are approved HIPAA contacts.
If not specify allowed family members above.

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Coventry Eye Asssociates, P.C., 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, including refractions and contact lens related charges. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on my insurance submissions. I understand that payment is expected at the time of the service. I give consent for any doctor at Coventry Eye Associates to speak to any doctor affiliated with my care. 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

X

Signature Date

Coventry Eye Associates, P.C.
800 Coventry Drive
Phillipsburg, NJ 08865
Phone: 908-859-6055
Email:

Please attach all pertinent insurance ID cards for photocopying.