Coastal Jersey Eye Care Patient Registration Information

(To Be Completed In Full**)**

You must present identification and insurance cards each time you come to the office

Date: ______________

Patient Name: _________________________________ Date of Birth _____________ Male____ Female_____

Full legal name - no nicknames please

____

Street Address Apt # City State Zip

Primary Phone #__________________________ Secondary Phone# (required)_________________________

(this is the number we will contact you)

Marital Status _____________ Social Security # _________________________ Occupation __________________

(REQUIRED BY LAW)

Employer __________________ Employer/Address ____

Email _________________________________(We do not share emails with anyone. We may send you an occasional update about new and interesting eyecare developments and Optical coupons!)

Please circle : **This information is requested due to Healthcare Reform laws per Federal Gov't**.

1. Race: Caucasian African-American American Indian Asian Native Hawaiian Other___________

2. Ethnicity: Hispanic/Latino Non Hispanic/Non Latino

3. Preferred Language : English Spanish Other_________________

Referring Physician (if applicable)____

Name City Phone

Primary Care Physician: ____

Name City Phone

Emergency Contact Person ______________________ Relationship to patient _________________________

Emergency Contact Phone ______________________

How did you hear about us? [ ] Doctor Referral [ ] Family/Friend [ ] Newspaper Ad

[ ] Phone Book [ ] Internet [ ] Other____________

#1 Primary Medical Insurance Carrier:____

Policy Number (I.D. #) __________________________ Group Number ______________________

Subscriber Name __________________________________ Date of Birth _______________ M or F _______
Full Name

Relationship _______________________________ Subscriber's Social Security # ____________________

#2 Secondary Medical Insurance Carrier:____

Policy Number (I.D. #) _____________________________ Group Number:______________________

Subscriber Name:_________________________________ Date of Birth:_______________ M or F:_______
Full Name

Relationship:______________________________ Subscriber's Social Security #:____________________

#3 Vision Plan Carrier (Cover Routine Exams, Eyeglasses, or Contacts):____________________

Policy Number (I.D. #) __________________________ Group Number: ______________________
Example – VSP, EyeMed

Who is the Subscriber __________________________________ Date of Birth:_____________ M or F:_____
Full Name

Relationship:_______________________________ Subscriber's Social Security #:______________________

MINORS/POWER OF ATTORNEY

All patients who are not 18 or older must have a parent or legal guardian present with them at each appointment. Patients who have a designated Power of Attorney (POA) for Healthcare and Legal POA must provide documentation of POA and must sign this form for the patient. The POA must also provide us with their name, address, and telephone number.

Authorizations

A. I hereby authorize Coastal Jersey Eye Center and/or any of its employees to bill any and all of my insurance providers for services rendered to me by the physicians and/or staff of CJEC. I authorize the release of any of my personal information so that benefits may be paid directly to CJEC.
B. I authorize CJEC to access & process my prescription medicine information electronically.
C. If a referral is required by my insurance, I understand it is my responsibility to have it PRIOR to my visit at CJEC.
D. I acknowledge that I have received the CJEC Notice of Privacy.
E. I acknowledge that this authorization will remain in effect from that date of my below signature unless I change it.
F. I acknowledge that I am financially responsible for any and all charges related to my visit. Once my insurance company has replied to the claim, it is my responsibility to resolve any and all outstanding balances or issues with the insurance company.
G. I acknowledge that any applicable co-pays and deductibles are due ON date of service.
H. I acknowledge that any balance over 60 days may be turned over to a collection agency unless I make payment arrangements with this office.

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Signature of Patient or POA   Print Patient's Name   D.O.B.   Date

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POA Name, Address, and Telephone (If Applicable)