EMPIRE EYE PHYSICIANS & EMPIRE EYE SURGERY CENTER
PATIENT REGISTRATION

PATIENT INFORMATION – Please Print

Patient Last Name	First Name	Middle	Date of Birth

Address – Street or Route	Sex ○ M ○ F	Social Security Number

City, State & Zip Code	Cell Phone	Home Phone	Work Phone

Referring Doctor	Marital Status
Email Address	○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

RESPONSIBLE PARTY – Bill To or Head of Household

Name	Relationship to Patient	Home Phone Number

Physical Address (Not PO Box)	City, State & Zip	Work Phone Number

Mailing Address	City, State & Zip	Employer Name

Employer Address	City, State & Zip

NOTIFY IN CASE OF EMERGENCY – (Person Not Living With You)

Name	Relationship to Patient	Home Phone Number

Address	City, State & Zip	Work Phone Number

INSURANCE INFORMATION & SUBSCRIBER INFORMATION

Insurance: ☐(YES) or ☐(NO) Family Physician: _____, MD

If your insurance is an HMO or Managed Care Plan which requires a referral you will be responsible for calling your primary care physician in advance of your appointment (usually the week prior) for an insurance referral. A referral must be in place at time of service or we will need to reschedule your appointment.

Medicare Number (We will need to copy your card)	Medicaid Number (We will need to copy current coupon)

Primary Insurance Company	Subscriber (Policy Holder) Name	Subscriber / Patient Relationship

Subscriber Employer	Subscriber Social Security Number	Subscriber Date of Birth

Primary Insurance Policy ID Number	Primary Insurance Policy Group Number	Copay (due at time of service) $ _____

Secondary Insurance Coverage

Secondary Insurance Company	Subscriber (Policy Holder) Name	Subscriber / Patient Relationship

Subscriber Employer	Subscriber Social Security Number	Subscriber Date of Birth

Insurance Policy ID Number	Insurance Policy Group Number

AUTHORIZATION

Permission For Treatment: I hereby authorize the physician and / or assistants for the care of the patient named on this record to administer any treatment as may be deemed necessary including the examinations or treatment that may be ordered to be performed by clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatments performed. **Assignment of Benefits:** I hereby authorize my insurance company(s) to pay Empire Eye Physicians directly. I also understand I am financially responsible for all services provided and agree to pay upon request for related charges or remaning services provided at Empire Eye Physicians or the Empire Eye Surgery Center. Payment is made only for covered services or procedures when certain rules are met. I understand this and am aware that I am financially responsible for all services and procedures provided that are not covered by Medicare or my Health Insurance Carrier. **(HIPPA) Health Insurance Portability and Accountability Acct:** New Privacy practices have been established to the privacy rule under the Health Insurance Portability and Accountability Act. I have been informed of my right to view the HIPPA policies for Empire Eye Physicians and the Empire Eye Surgery Center. **Permission for Release of Medical Information:** I understand and agree that any of the above information may be used, if necessary, for purposes of communication for appointment changes, accounts receivable, emergencies, etc. Information from my medical records may be released, if necessary, for insurance purposes.

Signature _____ **Date:** _____

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Empire Eye Physicians * 1414 N Houk Road, Suite 103 * Spokane, WA 99216 * (509) 928-8040
Empire Eye Surgery Center * 1414 N Houk Road, Suite 102 * Spokane, WA 99216 * (509) 922-3937
Empire Eye Physicians * 8445 N Government Way * Hayden, ID 83835 * (208) 762-0605