

Laconia Eye & Laser Center

PATIENT REGISTRATION				
Name:	Marital Status (Please Circle) S M W D	Date of Birth:	Sex:	Social Security Number:
Address: STREET CITY STATE ZIP				
Primary Care Physician:		How would you like us to contact you? (check all that apply) [] Home Phone [] Cell Phone [] EMail		
Home Phone:	Cell Phone:	Email:		
EMERGENCY CONTACT: Name/Telephone				
Employed: (Please circle) FT PT Self Employed Retired Not Employed		Military Status: (Please circle) Active Duty Reserves Retired Non-Military		Student Status: (Please circle) FT PT Not A Student
Employer Name/Telephone		How Did You Hear About Our Office?		
HIPAA – Disclosure of Information				
May we leave messages on your home telephone answering machine to confirm appointments? [] Yes [] No				
If you would like us to be able to discuss your eye care with anyone other than yourself, please list the name, relationship and telephone number below				
Name:	Telephone Number:	Relationship:		
Name:	Telephone Number:	Relationship:		
I have been offered a copy of or have read the Laconia Eye Associates, PA "Notice of Privacy Practices." Your Initials _____				
GUARANTOR INFORMATION				
Name:			Date of Birth:	
Address:				
Home Telephone:		Guarantor's Employer:		
Power of Attorney (If Applicable):				
Name:		Address:		Telephone Number:
INSURANCE INFORMATION				
Primary Insurance:		Certificate Number:		
Subscriber:		Group Number:		
Patient Relationship to Subscriber (Please circle) Self Spouse Child Other		Subscriber Date of Birth:		Subscriber Employer:
Secondary Insurance:		Certificate Number:		
Subscriber:		Group Number:		
Patient Relationship to Subscriber (Please circle) Self Spouse Child Other		Subscriber Date of Birth:		Subscriber Employer:

INSURANCE AUTHORIZATION AND CONSENT

I hereby authorize Laconia Eye Associates, PA, dba: Laconia Eye & Laser Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE (PATIENT OR REPRESENTATIVE)

DATE