ELANDER EYE MEDICAL GROUP, INC.

242 26th Street, Santa Monica, CA 90402
(310)393-0634

PATIENT REGISTRATION

FIRST NAME:_____ **INIT:**____ **LAST NAME:**_____

SEX:____ **M** ____ **F** **PARENT'S NAME (FOR MINORS):**_____

DATE OF BIRTH:_____ **AGE:**_____ **SS #:**_____

ADDRESS:_____

CITY/ZIP:_____

ALTERNATE ADDRESS:_____

_____

HOME PHONE:_____ **WORK PHONE:** _____

CELL PHONE: _____ **EMAIL ADDRESS:**_____

MARITAL STATUS:_____ **STUDENT STATUS:**_____

OCCUPATION:_____ **EMPLOYER:**_____

EMERGENCY CONTACT:_____

RELATIONSHIP:_____

ADDRESS:_____ **PHONE:**_____

INSURANCE INFORMATION:

MEDICARE NUMBER:_____

INSURANCE NAME:_____ **SUBSCRIBER:**_____

ADDRESS:_____ **ID#:**_____

_____ **DATE OF BIRTH:**_____

_____ **SEX:** _____ **M** _____ **F**

GROUP #:_____ **EFFECTIVE DATE:**_____

PATIENT'S AUTHORIZATION: By signing below, I attest that the above information is true and correct. I agree to be financially responsible for any services provided by EEMG, Inc. if the insurance information is not correct, not covered by my plan, or the required authorizations or referrals have not been obtained. I hereby authorize any holder of my medical information to release said information to the Health Care Financing Administration, Insurance Company, other medical providers or financial institutions and/or Elander Eye Medical Group, Inc. for the purposes of treatment, payment or health care operations. I further authorize payments from my insurance company to be made directly to Elander Eye Medical Group. I understand that EEMG, Inc. will bill my insurance as a courtesy to me, and I am ultimately financially responsible.

PATIENT SIGNATURE: _____ **DATE:**_____

REFERRAL SOURCE:_____ **FAMILY PHYSICIAN:**_____