PATIENT REGISTRATION

The surgery center requires the following information in order to file an insurance claim(s) on the patient's behalf. Claims are processed by the insurance company according to the patient's specific plan benefits; Deductibles, Co-insurance, and Non-covered service charges may apply and are the responsibility of the patient.

PATIENT NAME	DATE OF BIRTH	SEX	RACE
ADDRESS			
HOME PHONE	CELL PHONE	WORK /ALTERNATE PHONE	SOCIAL SECURITY NUMBER

FLU VACCINE ☐ Y ☐ N	PNEUMO VACCINE ☐ Y ☐ N	DEFIBRILLATOR ☐ Y ☐ N	ADVANCED DIRECTIVE ☐ Y ☐ N
ALLERGIES ☐ Y ☐ N Please List	LATEX ALLERGY ☐ Y ☐ N Reaction	TB STATUS ☐ Pos (+) ☐ Neg (-)	
EXPOSURE TO COMMUNICABLE/INFECTIOUS DISEASE ☐ Y ☐ N Please Explain	ANY SPECIAL NEEDS ☐ Y ☐ N Please List		

PRIMARY CARE PHYSICIAN	PHONE	FAX
EMERGENCY CONTACT	PHONE	RELATIONSHIP TO PATIENT

SURGEON	DATE OF SURGERY	TRANS	FEE
PROCEDURE (Description & Code)	DIAGNOSIS (Description & Code)		EYE
PROCEDURE (Description & Code)	DIAGNOSIS (Description & Code)		EYE

PRIMARY INSURANCE COMPANY	IDENTIFICATION #	GROUP #
INSURANCE COMPANY ADDRESS	PHONE	REFERRAL/AUTHORIZATION
POLICYHOLDER	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY	IDENTIFICATION #	GROUP #
INSURANCE COMPANY ADDRESS	PHONE	REFERRAL/AUTHORIZATION
POLICYHOLDER	DATE OF BIRTH	RELATIONSHIP TO PATIENT

I, ____ authorize payment of Medicare and/or other insurance benefits be made on my behalf to the Bergen-Passaic Cataract Surgery and Laser Center, Inc for any services furnished to me by this provider. I accept responsibility for payment for any service(s) not covered by my insurance.

I authorize Bergen-Passaic Cataract Surgery and Laser Center, Inc to use/and or disclose my health information to CMS and its agents or any other provider or insurance carrier for the purpose of determining the benefits payable for related services, processing claims and/or care or treatment. I understand that I may revoke this consent at any time by notifying Bergen-Passaic in writing and that this authorization will be effective until such time as I revoke it.

I authorize Bergen-Passaic Cataract Surgery and Laser Center, Inc to contact me, my emergency contact and/or leave information on my answering machine as necessary.

____________________ Date

____________________________________ Signature Of Patient Or Legal Guardian