NEW PATIENT REGISTRATION

PLEASE PRINT

DATE: _____

NAME: Mr. Mrs. Ms. Dr. (circle title) _____

MARITAL STATUS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

CELLULAR PHONE: _____

WORK PHONE: _____

E-MAIL ADDRESS _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

MEDICAL DOCTOR & PHONE #: _____

HOW DID YOU HEAR ABOUT RITTENHOUSE EYE ASSOCIATES? (CIRCLE ALL THAT APPLY)

FRIEND/ CO-WORKER HEALTH PLAN INTERNET DOCTOR AD OTHER

IF YOU HEARD ABOUT THE PRACTICE THROUGH A SPECIFIC PERSON, PLEASE WRITE THEIR NAME. _____

INSURANCE COVERAGE, IF ANY: _____

INSURANCE # (IF APPLICABLE): _____

SUBSCRIBER'S NAME: _____ (WHOSE NAME IS INS IN?)

SUBSCRIBER'S DATE OF BIRTH: _____

EMERGENCY CONTACT PERSON AND PHONE NUMBER:

YOUR LIFETIME RELEASE AND AUTHORIZATION

"I request that payment of the authorized Medicare (AND Medigap) benefits or authorized health insurance benefits be made to Rittenhouse Eye Associates for any services furnished me by any physician associated with Rittenhouse Eye Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, or any health insurance program to which I am a member any information needed to determine these benefits or the benefits payable for related services."

PATIENT'S (OR PATIENT'S GUARDIAN'S SIGNATURE):

_____