

PATIENT REGISTRATION FORM

The Mount Sinai Medical Center, Department Of Ophthalmology
Box 1183, 17 East 102nd St., 8th Floor West, New York, NY 10029
(Please complete and bring with you on the day of your appointment)

NEW

REVISED

DATE: PHYSICIAN:

PATIENT NAME: Last First M.I. Sinai Unit No.:

Birth Date: Sex(M/F) Social Security No.:

Home Address: Street Apt. # City State Zip

Home Telephone: Day Telephone:

Employer Name & Address:

GUARANTOR INFORMATION: (If patient is a child, please give parent information)

Name: Social Security No.:

Birth Date: Day Telephone:

Employer Name And Address:

NEXT OF KIN: (Emergency Contact Person)

Name: Relationship: Telephone:

Address:

PHYSICIAN REFERRAL:

Name Of Doctor Who Referred you: Telephone:

Address:

The office policy is that payment for services is expected at the time of your visit. Reimbursement will then be made to you by your insurance carrier. EXCEPTION: Medicare and insurance plans in which we participate. Please be assured that we will make every effort to cooperate with you if this policy presents hardship.

INSURANCE INFORMATION

PRIMARY

Company Name & Address:

Insured's Name:

Policy ID Number:

Patient's Relationship to Insurance Holder:

Self Spouse Child

SECONDARY

Company Name & Address:

Insured's Name:

Policy ID Number:

Patient's Relationship to Insurance Holder:

Self Spouse Child

IF MEDICARE IS YOUR SECONDARY INSURANCE, PLEASE FILL OUT PRIMARY INSURANCE INFORMATION AND COMPLETE MEDICARE SECONDARY PAYOR QUESTIONNAIRE ATTACHED

AUTHORIZATION AND CONSENT

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made directly to the above named physician on any unpaid bills or services provided on or after today. I also authorize any holder of medical or other information about me to release to their health care financing administration, its intermediaries, insurance companies, or their agents any information needed to determine benefits payable for services. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Patients Signature Or Authorized Representative

Date