Wentz Eye Care, P.A. Patient Registration Form

Date: ____ / ____ / _____

Demographic Information

Patient Name: _____ **Nickname:**_____
(Last) (First) (MI)

Address: _____ **Home Phone:** (_____) _____ - _____

_____ **Work Phone:** (_____) _____ - _____

_____ **Cell Phone:** (_____) _____ - _____
(City) (State) (Zip)

E-mail: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ E-Mail

SSN #: _____ - _____ - _____ **Birthdate:** ____ / ____ / _____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Widowed

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Unemployed

Occupation: _____ **Employer/School Name:** _____

Primary Doctor: _____

Referred by: ☐ Other Patient: _____ ☐ Other Doctor: _____
☐ Internet ☐ Newspaper ☐ Walk-by/Drive-by ☐ Phone Book ☐ School Nurse ☐ Insurance ☐ Other

Guarantor Information (write "SAME" if Patient is the Guarantor)

Name: _____ **Relationship:** ☐ Spouse ☐ Parent ☐ Other
(Last) (First) (MI)

Address: _____ **Home Phone:** (_____) _____ - _____

_____ **Work Phone:** (_____) _____ - _____
(City) (State) (Zip)

Insurance Information (all insurance cards must be presented on the date of service)

Primary Insurance

Name: _____ **Policy ID #:** _____

Insured Information **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other
(write "SAME" if Patient is the Insured)

Name: _____ **Employer/School Name:** _____
(Last) (First) (MI)

Address: _____ **Sex:** ☐ Male ☐ Female

_____ **Birthdate:** ____ / ____ / _____

_____ **Home Phone:** (_____) _____ - _____
(City) (State) (Zip)

(Please Complete the Back Side Also)

Secondary Insurance

Name: _____ **Policy ID #:** _____

Insured Information **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other
(write "SAME" if Patient is the Insured)

Name: _____ **Employer/School Name:** _____
(Last) (First) (MI)

Address: _____ **Sex:** ☐ Male ☐ Female

_____ **Birthdate:** ____ / ____ / _____

_____ **Home Phone:** (_____) _____ - _____
(City) (State) (Zip)

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

_____
Names of Insurance Company / Companies

And assign directly to Wentz Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize Wentz Eye Care to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ / _____ / _____
Signature Dated

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that I received a copy of the Notice of Privacy Practices of Monte S. Wentz O.D. I authorize Dr. Wentz and his staff to discuss my medical information with the following people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that I must notify Dr. Wentz in writing if I wish to change the list of people I have provided above.

_____ _____ / _____ / _____
Signature Dated