THE EYE INSTITUTE OF SILICON VALLEY

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PATIENT REGISTRATION

(Please Print and Complete)

(성함) (생일)
Patient's Name:_____ _____ M__ F__ Birth date:_____
(소셜 시큐리티 번호) Last (성) First
S.S.#_____ _____ Marital Status: Single / Married / Widow / Divorced

(주소) Address:_____ _____ City:_____ Zip:_____

Home Ph.# _____ _____ Cell # _____ Work# _____

Spouse / Significant Other_____ _____ S.S. # _____ DOB_____
(배우자 혹은 매우 가까운친지) (생일)

EMPLOYER (직장)

Patient Employed by: _____ _____

If patient is a minor: Mother's Name._____
(만소자인 경우) Father's Name._____

EMERGENCY CONTACT (매우 가까운 사인 경우 연락처)

(NOT LIVING WITH YOU)

Name:_____ _____ Phone # _____

Relationship: (환자와의 관계) _____

INSURANCE INFORMATION

Primary Insurance Company:___ _____

Policy Through: Self_____ Spouse _____ Other _____ DOB _____

Secondary Insurance Company: _____

Policy Through: Self_____ Spouse _____ Other _____ DOB _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of by treatment necessary to process insurance claims. It is your responsibility as holder of the insurance policy to check your insurance coverage. I understand that I am financially responsible for all charges for service rendered.

A finance charge of 1.5% may be added monthly for accounts outstanding after 60 days. I have read and understand.

Date:_____ _____ **Signed** _____