Pingree Eye Center

PATIENT REGISTRATION FORM

Patient Information

Name: _____ Gender: ❒ Male ❒Female

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Home Address: _____ Home Phone: (_____)_____

City/State _____Zip_____ Work Phone: (_____)_____

E-Mail Address: _____ Cell Phone: (_____)_____

Employer Name: _____

Preferred Language: ❒ English ❒ Spanish ❒ Other

Race: ❒ Asian ❒ Native Hawaiian ❒ Other Pacific Islander ❒ Black/African American

❒ American Indian ❒ White ❒ More than one race

Ethnicity: ❒ Latino or Hispanic Identity ❒ Not Latino or Hispanic Identity

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Parent or Person Responsible for Bill *(if different from above)*:

Guarantor Name: _____ Social Security Number: _____-_____-_____

Relationship to Patient (check one): ❒ spouse ❒ parent ❒ Other Date of Birth _____/_____/_____

Address: _____

Street City/State/Zip

Employer Name: _____ Phone: (_____)_____

Emergency Contact Information: Name: _____

Address: _____ Relationship: _____

Home Phone: (____)_____ Work or Cell Phone: (____)_____

Primary Insurance Information

Plan Name: _____ ID # _____

Policy Holder: _____Policy Holder's Social Security Number: _____-_____-_____

Policy Holders Date of Birth: _____/_____/_____

Secondary Insurance Information

Plan Name: _____ ID # _____

Policy Holder: _____ Policy Holder's Social Security Number: _____-_____-_____

Policy Holders Date of Birth: _____/_____/_____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Michael F. Pingree, M.D. I acknowledge that I am financially responsible for payment whether or not covered by insurance. **TERMS:** Net 15 days from the date of the invoice unless otherwise indicated above. A finance charge of 1½ per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 33% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

Signature: _____ Date: _____