Registration :

Albany Eye Associates

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate / Age	Social Security #

Address	Home: / Work: / Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician

Family Physician	Referring Physician

Medical Insurance

	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)

1

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2.

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1.

Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2.

Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I understand that any unpaid balance over 30 days old will be charged a finance charge of 18% per annum. A billing fee of $5 per month will be added to all co-payments not paid on the date of service. If this account is turned over to a collection agency and/or attorney for collection, I agree to pay reasonable attorney fees, collection fees, and court costs as applicable.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services redered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Albany Eye Associates
63 Shaker Road,
Albany, NY 12204
Phone: 518-434-1042
Email :

Please attach all pertinent insurance ID cards for photocopying.