ISLAND EYE SPECIALISTS

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MICRONESIA'S REGIONAL EYE CENTER SINCE 1997

Robert S. Jack, M.D Ophthalmology
G. Paul Burton, M.D Ophthalmology
Anthony J. Smith, III, M.D Ophthalmology
James V. McDarby, MD FACS Ophthalmology
Charles W. Flowers, M.D Cornea Specialist/ LASIK
Cuong Huynh, O.D Optometry

PATIENT REGISTRATION

Today's Date:	Primary Care / Referring Physician:	Clinic:

PATIENT INFORMATION

Last Name: First: Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Birth Date: / / Age:	Sex: ☐ M ☐ F
Marital Status: Single / Married / Divorced / Separated / Widowed	Email Address:		

Street Address:	Social Security No.:	Home Phone No.:

Mailing Address	City:	State:	ZIP Code:	Cell / Other Contact No.:

Occupation:	Employer and Address:	Employer / Work Phone No. ext:

INSURANCE INFORMATION

[Please give your insurance card(s) to the front desk]

Please indicate PATIENTS primary insurance	☐CALVO'S SELECTCARE	☐TAKECARE FHP	☐ STAYWELL _____	☐ VETERANS AFFAIRS	☐ TRICARE _____	☐ BLUE CROSS BLUESHIELD

☐AETNA	☐ NETCARE	☐MEDICARE	☐ MEDICAID	☐MIP	☐Other:

Subscriber's Name:	Subscriber's SS No.:	Birth Date: / /	Policy / Group No.:

Patient's relationship to subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Policy No.:	Other Insurance (if any):

Patient's relationship to subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____	Co-Pay:

Person responsible for bill (if other than SELF)	Birth Date: / /	Home Phone No.:	Work Phone No.:	Other Phone No.:

Is this person a patient here? ☐ YES ☐ NO Address (if any):

Occupation:	Employer and Address:	Employer Phone No.:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone No.:	Work Phone No.:	Other Phone No.:

FINANCIAL ASSIGNMENT AND AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance. In order to control your billing costs, we request that all set fees and co-payments be paid upon check-in and/or charges for services rendered be paid at the conclusion of each visit. The above information is true to the best of my knowledge. With my signature, I am aware and agree to the statements on this form and consider this form or a photocopy of it valid, until revoked by me in writing. I authorize my insurance benefits be paid directly to the physician. **I understand that I am financially responsible for ANY and ALL balances.** I also authorize **ISLAND EYE** or the insurance company to release any information required to process my claims & secure payment.

_____ _____

Signature Date