

REGISTRATION FORM

MICROSURGICAL EYE CONSULTANTS

DENNIS F. STOLER, M.D. • WILLIAM B. ORENBERG, M.D. • JEFFREY A. SORKIN, M.D.
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STEPHEN J. HARNEY, O.D. • RODNEY L. IMMERMANN, O.D. • REEM R. PARSEGHIAN, O.D.

ACCOUNT # _____

PERSONAL INFORMATION

NAME _____ E-MAIL: _____
 MALE FEMALE
CELL PHONE () _____ HOME PHONE () _____
HOME ADDRESS/STREET _____ CITY _____ STATE _____ ZIP _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____
OCCUPATION _____ SOCIAL SECURITY NUMBER _____
EMPLOYER _____ WORK PHONE () _____
EMPLOYER ADDRESS/STREET _____ CITY _____ STATE _____ ZIP _____
SPOUSE'S NAME _____
SPOUSE'S OCCUPATION _____ SPOUSE'S WORK PHONE () _____
REFERRED BY _____
REASON FOR VISIT _____
IN CASE OF EMERGENCY, PLEASE NOTIFY _____ PHONE () _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN _____ ADDRESS _____ PHONE () _____
ALLERGY LIST: _____ MEDICATION LIST: _____
DO YOU WEAR: CONTACT LENSES _____ GLASSES _____

INJURY INFORMATION

DATE OF INJURY _____ INDUSTRIAL ACCIDENT _____ WORK RELATED _____ OTHER _____
RESPONSIBLE PARTY _____ PHONE NUMBER () _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER'S NAME _____
POLICY HOLDER'S SS # _____ D.O.B. _____
INSURANCE ADDRESS _____
POLICY # _____ GROUP # _____
COMPANY NAME _____ COMPANY ADDRESS _____

SECONDARY INSURANCE _____ POLICY HOLDER'S NAME _____
POLICY HOLDER'S SS # _____ D.O.B. _____
INSURANCE ADDRESS _____
POLICY # _____ GROUP # _____
COMPANY NAME _____ COMPANY ADDRESS _____

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS TO PHYSICIAN: I hereby authorize assignment of payments directly to Microsurgical Eye Consultants for the surgical and/or medical benefits, if any, otherwise payable to me for the services described above. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize Microsurgical Eye Consultants to release any information relative to medical care received by me.

SIGNED _____ DATE _____
(Insured or Authorized Person)

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**31 CENTENNIAL DRIVE
PEABODY, MA 01960**

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Date: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgment. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting: Jeffrey Sorkin, M.D. (Privacy Officer here at Microsurgical Eye Consultants).

By signing this form, you acknowledge receipt of our Privacy Notice and consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature: _____

Date: _____