PEDIATRIC
REGISTRATION FORM

MICROSURGICAL EYE CONSULTANTS

JEFFREY A. SORKIN, M.D.
PEDIATRIC OPHTHALMOLOGIST

ACCOUNT# ________________

PATIENT NAME ______________________________ BIRTH DATE ____/ _____ / _____ ☐M ☐F AGE ______

ADDRESS ______________________ CITY ________________ STATE ________ ZIP __________ SS# ________________

HOME # ( ) ______________________________ CELL # ( ) ______________________________

MOTHER'S NAME ______________________________ E-MAIL: ______________________________

EMPLOYER ADDRESS ______________________________ WORK# ( ) ________________

ADDRESS (If different from patient) ________________ CITY ______________ STATE ________ ZIP __________

FATHER'S NAME ______________________________ E-MAIL: ______________________________

EMPLOYER ADDRESS ______________________________ WORK# ( ) ________________

ADDRESS (If different from patient) ________________ CITY ______________ STATE ________ ZIP __________

FAMILY STATUS: PARENTS ARE: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

PATIENT IS: ☐ LIVING WITH PARENT(S) ☐ LIVING WITH RELATIVE, GUARDIAN, OR FOSTER PARENT

PEDIATRICIAN ________________ ADDRESS ______________________________ PHONE# ( ) __________

REFERRED BY ____

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________________ POLICY HOLDER'S NAME ________________________

POLICY HOLDER'S SS# ______________________________ POLICY HOLDER'S 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)

MICROSURGICAL EYE CONSULTANTS

DENNIS F. STOLER, M.D., P.C., F.A.A.O.
WILLIAM B. ORENBERG, M.D., P.C., F.A.A.O.
JEFFREY A. SORKIN, M.D., F.A.A.O.

31 CENTENNIAL DRIVE
PEABODY, MA 01960

978-531-4400
FAX: 978-531-7106

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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: ____