## Registration :

| 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: | How did you hear of us? |
|---|---|---|
| | Work: | |
| Address 2 | Cell: | |
| | 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 | Copay | 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: |
|---|---|---|---|---|---|---|
| | | | | | | |

**HIPAA - list in the section above the person or family member to whom you wish to have access to your medical or insurance information**

American Indian or Alaska Native Other

### Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Helga Fuenfhausen Pizio, MD, LTD and Jeffrey K. Austin, OD, LTD, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. Jeffrey K. Austin, OD, LTD is an Independent Contractor for Helga Fuenfhausen Pizio, MD, LTD dba New Eyes. I acknowledge receipt of the practices' Notice of Privacy Practices. I authorize the practices to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

| Signature | Signature Date | |
|---|---|---|
| X | | Phone:<br>Email: |

**Please attach all pertinent insurance ID cards for photocopying.**