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
RACE: (circle one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White Declined to specify
ETHNICITY: (circle one): Hispanic or Latino NOT Hispanic or Latino Declined to inform
Language (circle one): English Spanish 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 or opportunity to recieve 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: Email:

Please attach all pertinent insurance ID cards for photocopying.