CHART #_____ **NS.**_____ **PVT MR MD MRD REFR Y N**

LUIS MENDOZA, MD **ALLISON GUNZBURG, MD**

WELCOME TO

CLIFTON◯ PASSAIC◯ EYE SPECIALISTS

CARMEN GONZALEZ, MD

PATIENT REGISTRATION FORM

Have you been a patient of our practice? ☐ Yes ☐ No - Recommended by: ❑ Dr._____**❑ Insur ❑ Relative ❑ Friend**

Method of Personal Payment: ☐ Cash ☐ Check - if by Check Drivers License number_____

CELLULAR (_____) _____-_____

Patient: FIRST NAME MI LAST NAME ☐ FEMALE BIRTH DATE AGE HOME PHONE

☐ MALE _____/_____/_____| |_____| (_____)_____

Month Day Year

_____MARITAL STATUS

❑ Single ❑ Married EMPLOYED RETIRED DISABLED

■ Divorced ❑ Separated ❑ YES ❑NO ❑ YES ❑ NO ❑ YES ❑ NO

_____❑ Widow ❑ Widower

PROFESSION OR JOB_____

Street_____

ADDRESS

SOCIAL SECURITY No_____

_____

CITY STATE ZIP

E-MAIL _____

_____

NAME , ADDRESS AND PHONE OF YOUR PLACE OF WORK IF YOU ARE OVER 18 YR-OLD AND FULL TIME STUDENT SCHOOL NAME AND ADDRESS

WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU? _____ RELATIONSHIP_____

INSURANCE INFORMATION: DO YOU HAVE A **CURRENT** HEALTH INSURANCE? ◉ YES ; ◯ NO

DO YOU HAVE MORE **THAN ONE** HEALTH INSURANCE? ◯ YES ; ◯ NO

DEDUCTIBLE: NO_, IF YES_, HOW MUCH $_____

PRIMARY INSURANCE:_____ STARTING DATE:_____/_____/_____

SECONDARY / GAP/ SUPPLEMENTARY INSURANCE::_____STARTING DATE:_____/_____/_____

IS YOUR INSURANCE THROUGH: ◯ YOUR EMPLOYER; ◯ HUSBAND; ◯ WIFE; ◯ FATHER; ◯ MOTHER; OR ◯ SELF

UNIFORM ASSIGNMENT, RESPONSIBILITY OF PAYMENTS AND RELEASE OF INFORMATION STATEMENT

I hereby assign or transfer benefits made to me or on my behalf to Dr. Mendoza, Dr. Gunzburg, Dr. Gonzalez, for any services furnished to me by any of these physicians. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. **I agree that any insurance payments sent to me that belongs to any of the doctors I will bring to the office immediately.**

I hereby authorize Dr. Mendoza, Dr. Gunzburg, Dr. Gonzalez to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Responsible party or Patient's Signature_____

CHECKED BY_____ (INI)

Date_____