Advanced Artificial Eyes
18455 Burbank Blvd. Suite 202, Tarzana CA 91356

Patient Registration Form

PATIENT INFORMATION

Patient's Legal Name (Last, First, Middle): _____
Soc. Security No: _____ Date of Birth_____ Sex: ☐M ☐F ☐Other
Patient's Address: _____ City: _____ State: _____ Zip: ____
Cell Number: _____ Home Ph.: _____ Email Address: _____

Employer: _____ Emp. Address: _____City: _____State:____ Zip: _____
Employer Phone No.: _____ Extension No.: _____

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐Yes ☐No

Primary Care Physician/ Ophthalmologist/ Optometrist Names and Ph. No.: _____
_____

INSURANCE INFORMATION

Name of Primary Insurance: _____
Member/Policyholder (if different from patient): _____ Date of Birth: _____
Member/Policyholder ID#:_____ Group No.:_____ Insurance Co. Phone #: _____

EMERGENCY CONTACT

Name (Last, First, Middle): _____ Cell: _____ Email: _____
Street Address (Required):_____ City: _____ State: _____ Zip: _____
Relationship to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Other: _____

CREDIT CARD INFORMATION & AUTHORIZATION

Card Holder Name: _____ Credit/Debit Card Number: _____
Expiration Date: _____ CVV: _____ Zip/Postal Code: _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment. I will be subject to collections if I do not pay in full for the services rendered to me. I authorize Advance Artificial Eyes, Inc. to charge my credit or debit card for any and all copay, coinsurance, deductible, cancellation, and/or cosmetic upgrade fees agreed upon and owed to them. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signature: _____ Date: (Month/Date/Year): _____

Please bring the following items with you on your first appointment:

1. Your Prosthetic Eye Prescription and Approved Referral/Authorization Form
2. Photo ID, Insurance Card(s), and form of payment (Credit or Debit Card)
3. Any imaging or other studies that you would like to share with your provider
4. Medicare patients, please bring with you a complete list of all medications currently taking
5. Please arrive 10-15 minutes early on your appointment time to allow time to complete new patient paperwork.