REGISTRATION FORM

PATIENT INFORMATION: **Please Print:** Date: _____

Patient Name:
(Dr. Mr. Mrs. Ms. Rank) _____
(First) (Middle) (Last)

Street Address: _____ **e-mail address:** _____

City, State, ZIP: _____

Home Phone: _____ Business Phone: _____ Sex: Male _____ Female _____

Marital Status: M S W Age: _____ Patient Social Security # _____/ _____/ _____

Date of Birth: _____ Patient Employed by: _____

How did you learn about our office? _____

When was your last physical exam? _____ Family Physician: _____

Preferred Pharmacy _____ Address _____ Phone Number_____

Spouse Name: _____ Business Phone: _____

Nearest Relative or Friend not living with you (In case of emergency):

Name: _____ Relationship: _____

Address: _____ Phone: Home _____ Work _____

INSURANCE INFORMATION:

Policy Holder's Name: _____

Primary Insurance: _____ Effective Date: _____

Other Insurance: _____ Effective Date: _____

Method of Payment: _____Cash _____Personal Check _____Visa/MasterCard/Discover

AUTHORIZATION:

I understand that I am responsible for all charges for services provided by San Antonio Eye Center and/or the San Antonio Eye Surgicenter (Dudley H. Harris, M.D., P.A.). I understand that a $35.00 collection fee will be charged for accounts that require collection procedures. I authorize release of any medical information necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignments/participation with my insurance company.

_____ _____
Date Signature of Patient or Legal Guardian

MEDICARE LONG TERM AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to Dudley H. Harris, M.D., Jason Ming Zhao, M.D., David B. Abrams, M.D., Sora Hahn-Navas, M.D., Georgia S. Stephenson, M.D., Sanford E. Roberts, M.D., John N. Nicolau, M.D., Teresa Treviño Whitney, M.D., Aaron P. Erdmanczyk, O.D., Donald F. Semler, O.D., P.A., Gawain Dyer, M.D., Vasudha Panday, M.D., William R. Thorton, M.D., or San Antonio Eye Center Surgicenter for any service furnished me by San Antonio Eye Center (Dudley H. Harris, M.D., P.A.). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Date Signature of Patient or Legal Guardian

MEDIGAP AUTHORIZATION:

I request that payment of authorized Medigap benefits be made on my behalf to Dudley H. Harris, M.D., Jason Ming Zhao, M.D., David B. Abrams, M.D., Sora Hahn-Navas, M.D., Georgia S. Stephenson, M.D., Sanford E. Roberts, M.D., John N. Nicolau, M.D., Teresa Treviño Whitney, M.D., Aaron P. Erdmanczyk, O.D., Donald F. Semler, O.D., P.A., Gawain Dyer, M.D., Vasudha Panday, M.D., William R. Thorton, M.D., or San Antonio Eye Center Surgicenter for any service furnished me. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or benefits payable for related services.
(Name of Medigap Insurance)

_____ _____
Date Signature of Patient or Legal Guardian