Rock Hill Eye Center

Patient Registration Form

Patient Information

Patient's last name | First | Middle

Street address | City | State | ZIP Code

Sex | Preferred phone | Email

Marital status | DOB | Social Security number

Employer

Responsible Party Information

Responsible Party Name | Address (if different)

Sex | DOB | Social Security Number | Preferred Phone

Employer

Insurance Information (Please give your insurance card to the receptionist.)

Primary insurance | Group number | Policy number

Subscriber's name (if different) | Social Security number | DOB | Patient's relationship to subscriber

Primary insurance | Group number | Policy number

Subscriber's name (if different) | Social Security number | DOB | Patient's relationship to subscriber

Authorization

I hereby consent to the treatment for myself or patient listed on this form. I hereby certify that I assign all insurance benefits directly to Rock Hill Eye Center and I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. This authorization shall remain valid, until written notice is given by me, revoking said authorization.

Signature of Patient/Guardian | Date