MARYLAND EYE CONSULTANTS AND SURGEONS

OPHTHALMOLOGY AND OPHTHALMIC SURGERY

GREGORY J. LADAS, MD, FACS JOHN G. LADAS, MD, PHD, FACS KATHLEEN Z. LADAS, MD
WILLIAM D. O'DONNELL, MD PAMELA P. CHEUNG, MD STACY J. BANG, MD

PATIENT REGISTRATION

TODAY'S DATE :______________________

PATIENT NAME:

____
LAST FIRST M.

HOME ADDRESS:

____
STREET APARTMENT NO.

____
CITY STATE ZIP CODE

PHONE NOS: ____
HOME CELL WORK

BIRTH DATE: ________________ AGE: _________________ SEX: M F

MARITAL STATUS: S M D W SPOUSE NAME: ____________________________

EMPLOYER NAME AND ADDRESS:

____

OCCUPATION: ____

EMERGENCY CONTACT:

____
NAME PHONE NO. RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN:

____
NAME PHONE NO.

FAMILY OR REFERRING PHYSICIAN: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize billing services rendered by any of the above doctors. Payment from my insurance carrier(s) should be made directly to Maryland Eye Consultants and Surgeons.

I also agree to be held financially responsible for any services not covered by my insurance carrier(s).

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my health insurance plan in order to determine benefits which I may be entitled. (Or in case of part B benefits, to the Social Security Administration and Heath Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

____
SIGNATURE DATE