LAKELAND OPHTHALMOLOGY
973.331.0300
3799 Route 46 Parsippany, NJ 07054
RIGHT NEXT TO TGI FRIDAY'S

Welcome. Please tell us a little about yourself.

Patient Registration

Today's Date: _____/_____/_____ Primary Care Doctor: _____ Phone #_____

Name (last, first, middle): _____ _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Sex: M or F Date of Birth: _____/_____/_____ Age _____ Marital Status _____

SS # _____ (Check One) O Employed O Retired O Student O Other _____

Race:_____ Language:_____ Ethnicity:_____

Employer: _____

Employer Address: _____

Emergency Contact

Name _____ Relationship: _____ Phone # (_____) _____

Insurance Information.

Insurance Company: _____

Subscriber (Check One) O Self O Spouse O Parent O Other _____

Name of Subscriber (if other than patient) _____ DOB: _____SS#_____

Policy ID # _____ Group # _____

Secondary Insurance Company: _____

Please inform us if you have Vision Service Plan (VSP). Yes or NO

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits.

I acknowledge receipt of Lakeland Ophthalmology's Notice of Privacy Practices.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for all assigned claims. I request that payment of authorized insurance/Medicare benefits not assigned be made either to me or on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for any services furnished me by that supplier.

Signature: _____ **Date:** _____/_____/_____

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REGISTRATION FORM 3/23/18