Long Island Ophthalmic Care, P.L.L.C.

230 Hilton Ave, Suite 118
Hempstead, New York 11550
Tel: 516-481-1570 Fax: 516-481-1786

Patient Registration

Patient's Name **Date of Birth** **Age** **Patient's Social Security Number**

Home Address **City** **State** **Zip Code**

Home Phone **Cell Phone** **Work Phone**

Occupation **Employer's Name** **Email**

Race **Ethnicity** **Preferred Language**

Spouse's Name/Next of Kin **Pharmacy Name/Phone Number**

Primary Physician **Referring Physician**

Notify in Case of Emergency
Name **Relationship** **Telephone Number**

Financial Information: Person Responsible for Fees
Name **Address** **Telephone Number**

Insurance Company **Policy Number**

Subscriber's Name **Date of Birth** **Social Security Number**

Secondary Insurance **Policy Number**

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENTS: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by any insurance.

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Patient or Authorized Representative's Signature **Date**