Patient Registration

Patient Name: _____ Date of Birth____/____/____

Patient Address: _____ Male ☐ Female ☐

City: _____ State: _____ Zip Code_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Soc. Security #: _____-_____-_____

E-mail Address: _____

Primary Care Physician: _____ Phone#: _____

Address: _____

Insurance Information:

Primary Insurance Carrier: _____

Policy #: _____ Group #: _____

Copay: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder's D.O.B: _____

Secondary Insurance Carrier: _____

Policy #: _____Group #: _____

Please note: According to regulations, you must be notified of any procedure that is not covered by your insurance carrier. All co-payments and your deductible are your sole responsibility. Vision testing/Refraction and routine eye exams may not be covered under your insurance policy. Payment is expected at the time of the visit. Any account past due, over 45 days will be charged a $25 administration fee for the billing service per bill.

I hereby authorize Maple Eye and Laser Center to file insurance forms on my behalf.

Patient Signature:_____ Date_____/_____/_____

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Medical History:

Do you have any of the following conditions:

Diabetes □ yes □ no

High Cholesterol □ yes □ no

High Blood Pressure □ yes□ no

Seasonal Allergies □ yes □ no

Medication Allergies □ yes □ no if yes, please list: _____

Please list any other medical conditions: _____

_____

Medications:

Please list all medications you are taking:

_____

_____

_____

Previous Surgeries:

_____

_____

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MAPLE EYE AND LASER CENTER

Henry C. Oksman, M.D. • Howard S. Kornstein, M.D
Jacob D. Rosenbaum, M.D. • Kerry Keely, O.D

Dear Patients:

Insurance companies prohibit the doctor from collecting his/her fee directly from patients that are member of managed care plans. **You must submit a valid insurance card and any necessary referral information to the office prior to or at the time of your appointment.**

If we do not participate with your insurance plan you will be held responsible for payment and any correspondence with your insurance carrier.

If you did not have insurance or have not provided us with the correct insurance information at the time of your visit, you will be held responsible for payment.

Expected charges $ 225.00 for complete exam.

Patient name (Print) _____

Patient Signature _____

Date of service _____/_____/_____

PLEASE READ AND SIGN

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MAPLE EYE AND LASER CENTER

Henry C. Oksman, M.D. • Howard S. Kornstein, M.D
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As you are probably aware, a complete eye evaluation for medical purposes is a covered service by your insurance carrier for which I accept assignment (as long as your deductible and co-payments have been satisfied). The **evaluation of your vision, including giving you an eye prescription**, is considered **vision care** and is usually **not** a covered service. **In addition** to your co-payment there may be a **$35** fee for the determination of refraction.

Some plans may continue to provide you with vision care reimbursement. We will provide a professional services bill and receipt for your payment so that if your plan allows, you may obtain reimbursement.

We appreciate your understanding in this matter and look forward to continuing to serve you in the future as we have in the past. Thank you.

PLEASE SIGN

Sign: _____ Date:_____

Patients Name (If Minor):_____

PLEASE READ AND SIGN