

ADULT REGISTRATION FORM

EYE CLINIC OF
FAIRBANKS

WELCOME

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as accurately as possible.
We will be happy to answer any questions you may have.

116 Minnie Street
Fairbanks, Alaska 99701-3006
(907)456-7760

Please print

PATIENT INFORMATION

Patient's Name Mr. Ms. Mrs.	Date of Birth	Sex	Social Security No.	
Mailing Address	City	State	Zip Code	
Alternate Address, if any				
Home Phone	Work Phone/Ext.	Cell Phone	Your Pharmacy Name	Phone Number
Best time and place to reach you		Email Address:		
Employer (if self, name of business)	Dept/Position Held	Union/Local No.	Work Phone/Ext.	
Emergency contact (Specify someone who does not live with you)	Relationship	Home Phone	Cell Phone	Work Phone

SPOUSE INFORMATION

Spouse's Name Mr. Ms. Mrs.	Date of Birth	Sex	Social Security No.	
Mailing Address	City	State	Zip Code	Home Phone Cell Phone
Employer (if self, name of business)	Dept./Position Held	Union/Local No.	Work Phone/Ext.	

INSURANCE & BILLING INFORMATION

Complete for each company	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Company Name				
Insurance Address				
Policy or Group Number				
Subscriber ID Number				
Medicare Claim Number	- - -	- - -	- - -	- - -
Policy Holder's Name				
Policy Holder's Date of Birth				
Policy Holder's Soc.Sec.No.	- -	- -	- -	- -
Relationship to Patient				

AUTHORIZATION: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize the Clinic to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to the Clinic any vision/medical/surgical benefits due me that have not been paid. This authorization shall expire upon written notice or one year from this date.

_____ SIGNATURE	_____ DATE
_____ UPDATE	_____ DATE
_____ UPDATE	_____ DATE
_____ UPDATE	_____ DATE

NOTICE: There may be finance charge imposed on the unpaid portion of your bill at the Clinic.