BROADWAY VISION CENTER - DR. CHARLES GOLD

REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Today's date:			Email:	
Patient's last name:		First:		Middle:
Age:	Sex: ❑ M ❑ F			
Street address:		Social Security no.:		Home phone no.: ( )
Cell number: ( )	City:		State:	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)				
Is this patient covered by insurance?	❑ Yes ❑ No			
Insurance name:		Insurance ID#:		
Subscriber's name:		Birth date: / /		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name :	Relationship to patient:	Home phone no.: ( )	Cel phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Broadway Vision Center - Dr. Charles Gold or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

I acknowledge that I have received a copy of the Broadway Vision Center Notice of Privacy Practice, for protected health information.

Patient Signature: ____ Date: ________________________