Pediatric Eyecare of Northern Jersey
밝은아이안과

PATIENT REGISTRATION FORM

Patient's Name Last	First	Middle
Address		
City	**State**	**Zip Code**
Home Phone	Employer	
Cell Phone	Phone #	
Birth Date		
Sex female male (circle one)	Marital Status Single Married Separated Widowed Other	
Social Security No.	**E-Mail**:	
Pharmacy (name & location)	Phone	
Emergency Contact Name	Relationship	Phone
Family Doctor	Did He/She refer you here? YES ☐	NO ☐
Are you allergic to any medication?		

PRIMARY INSURANCE INFORMATION		
Insurance Company Name **:**		
Policyholder's Name : Last	First	Middle
Relationship to Patient self spouse father mother (circle one)		
Birth Date	Social Security No.	
SECONDARY INSURANCE INFORMATION		
Insurance Company Name :		
Policyholder's Name :		
Relationship to Patient self spouse father mother (circle one)		
Birth Date	Social Security No.	

I understand that my records are protected under HIPPA as you review the attached notification form.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient/guardian's Name:_____

Signature of Patient/guardian:_____ **Date:**_____

I hereby authorize JIMMY.H.JEE M.D. to apply for benefit on my behalf for covered services rendered by him. I request that payment form my insurance be made directly to the doctor. I understand that I am financially responsible for any unpaid balance by insurance company within 60 days of the date of service.
I certify that the information I have reported with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient/guardian's Name:_____

Signature of Patient/guardian:_____ **Date:**_____