Pediatric Eyecare of Northern Jersey
밝은아이안과

PEDIATRIC REGISTRATION FORM

Patient Name: Last First Middle		
Birth Date:	**Gender:** Male Female	
Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	
Work Phone:	**E-Mail:**	
Pharmacy:	**Phone**	
Pediatrician:	**Did He/She refer you here? YES NO**	
Father's Name:	**Mother's Name:**	
Birth Date:	**Birth Date:**	
Cell Phone:	**Cell Phone:**	

PRIMARY INSURANCE INFORMATION	
Insurance Company Name:	
Policyholder's Name: Last First Middle	
Relationship to patient: Self Spouse Father Mother	
Birth Date: MM/DD/YYYY	**Social Security No.**
SECONDARY INSURANCE INFORMATION	
Insurance Company Name:	
Policyholder's Name:	
Relationship to patient: Self Spouse Father Mother	
Birth Date: MM/DD/YYYY	**Social Security No.**

I understand that my records are protected under HIPPA as 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:**_____