NEW PATIENT REGISTRATION

(Please fill out **ALL** information)

PATIENT_____DATE_____

ADDRESS_____PHONE_____
STREET PO BOX

_____CELL_____
CITY STATE ZIP

EMAIL_____ SEX (M / F) BIRTH DATE_____AGE_____

EMPLOYER_____ WORK#_____

PRIMARY INSURANCE COMPANY_____

POLICY #_____ GROUP#_____

SUBSCRIBER'S NAME (+DOB) _____RELATIONSHIP TO INSURED:_____

SECONDARY INSURANCE COMPANY_____

POLICY #_____ GROUP#_____

SUBSCRIBER'S NAME (+DOB) _____RELATIONSHIP TO INSURED:_____

HOW DID YOU LEARN ABOUT DR. STRECKER?_____

WHO IS YOUR CURRENT EYE DOCTOR?_____company?_____

ADDRESS_____PHONE #_____

PRIMARY CARE DOCTOR (first and last name)_____

ADDRESS/MEDICAL GROUP_____ PHONE#_____ FAX#_____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY_____
RELATIONSHIP TO PATIENT

ADDRESS_____ PHONE#_____

MAY WE DISCUSS MEDICAL INFORMATION WITH THIS PERSON? YES / NO (PLEASE CIRCLE)

ALL PATIENTS:

I authorize the release of any medical information necessary to process my medical claims. I also request payment of government benefits or insurance benefits to Richard W. Strecker M.D.

I understand that I am financially responsible for co-payments and/or deductibles in accordance with the provisions of my insurance plan. If covered under an HMO, I understand it is my responsibility to obtain a referral (when required). I further understand that if I do not obtain a referral when it is required by my plan, coverage for services may be denied and it is my responsibility to make payment in full to Richard W. Strecker M.D. for these non covered services. I have read and understand this information:

Patient signature_____ Date:_____