

**OPHTHALMOLOGY ASSOCIATES  
THE CORNEA AND LASER VISION INSTITUTE**

**GREGG J. BERDY, M.D., F.A.C.S.  
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DIPLOMATES, AMERICAN BOARD OF OPHTHALMOLOGY  
DIPLOMATES NATIONAL BOARD OF OPTOMETRY

**PATIENT REGISTRATION SHEET**

Mr. Mrs. Miss Ms: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Sex: M F Marital Status: Single Divorced Married Widowed

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have medical insurance?  Yes  No Please complete if yes

Primary #1. \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber/Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber/Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_

If patient is a minor, please complete:

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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**PATIENT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ALL PATIENTS**

**CONSENT FOR TREATMENT:** I hereby authorize my doctor (or whomever he may designate) to administer such medical treatment, as is necessary for a patient in my condition.

**SIGNED:** (Patient \_\_\_\_\_  
or Parent, if Minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Ophthalmology Associates to release any and all information contained in my medical records pertaining to this treatment or series of treatments to my insurance company, third party carriers, or their representatives, and referring and/or consulting physicians.

**SIGNED:** (Patient \_\_\_\_\_  
or Parent, if Minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION FOR PAYMENTS OF BENEFITS:** I hereby authorize payment of medical and surgical benefits, provided by my insurance carrier, to Ophthalmology Associates.

**SIGNED:** (Patient \_\_\_\_\_  
or Parent, if Minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICARE PATIENTS**

**EXPLANATION OF MEDICARE ASSIGNMENT:** In Medicare assigned cases, the physician agrees to accept the charge determination of the fiscal intermediary as the full charge. I understand that I am responsible for the deductible co-insurance and non-covered services. Co-insurance and deductible are based upon charge determination of the Medicare carrier if this is less than the charge submitted.

**SIGNED:** (Patient \_\_\_\_\_  
or Parent, if Minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICARE SIGNATURE ON FILE:**

**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ophthalmology Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**SIGNED:** (Patient \_\_\_\_\_  
or Parent, if Minor) \_\_\_\_\_ **Date:** \_\_\_\_\_