



Board Certified Fellowship - Trained Eye Physician & Surgeon
2535 Capital Medical Boulevard
Tallahassee, Florida 32308
(850) 877-7337
Palmereye.com

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____
Today's Date: ____/____/____ Race: _____ Social Security #: _____ - _____ - _____
Sex: M / F Marital Status: S / M / D / W Height: _____
Date of Birth: ____/____/____ Age: ____ __ Driver License #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Alternate number: _____
Occupation: _____ Employer: _____
In case of emergency contact: _____ Relationship to patient: _____
Emergency contact number: _____

General Physician: _____ Phone Number: _____
Who referred you to Palmer Eye Center? _____
Reason for your visit today _____

Name of Insurance Company: _____
Policy Number: _____ Group Number: _____
Secondary Insurance Company: _____
Policy Number: _____ Group Number: _____

Please read and fill out the backside of this form as well

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare/other company benefits be made either to me or on my behalf to Eyes at Centerville Park/Palmer Eye Center/Richard M. Palmer, M.D., for any services furnished to me by that party which accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release it to the Social Security Administration and Health Care Financing Administration or it intermediaries or carriers, needed for this or a related Medicare claim/other insurance benefits. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____

Date: ____/____/____

All professional services rendered are charged to the patient. Our office will bill your insurance company for payment. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered.

Palmer Eye Center likes to thank our patients for allowing us to provide you with comprehensive eye care. From time to time we like to send you items we think you might enjoy. So those you are with every day might enjoy them too, we prefer to send them to your place of employment. If this sounds like something you are interested in please provide us with your exact employment address and telephone number plus extension.

Complete Employment Address:

Patient Signature

Date