ROCKY MOUNTAIN EYE CENTER, INC.
PATIENT REGISTRATION FORM

WELCOME TO OUR OFFICE! This form will aid us in ensuring that we submit your claim to your insurance company promptly and accurately. If your plan requires a referral, please provide it to the receptionist or advise us so that we may check to be sure we have received it. THANK YOU.

Payment for services or co-pay is expected at time of service.

PATIENT'S NAME FIRST M.I. LAST	NICKNAME	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS	CITY AND STATE ZIP CODE		GENDER
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY AND STATE ZIP CODE		HOME PHONE
PATIENT'S E-MAIL Implies Consent to Receive Electronic Communication	MARITAL STATUS S M W D SEP		CELL PHONE

RACE: ❑American Indian or Alaskan Native ❑Asian or Pacific Islander ❑Black ❑Caucasian ❑Hispanic ❑Unknown / Other

ETHNICITY: ❑Hispanic or Latino ❑Non-Hispanic or Latino **PREFERRED LANGUAGE**: _____

PATIENT'S EMPLOYER	ADDRESS CITY STATE ZIP CODE	BUSINESS PHONE
WHO IS YOUR PRIMARY CARE PHYSICIAN?	WHO REFERRED YOU TO US?	STUDENT FULL-TIME ☐ PART-TIME ☐
IN CASE OF EMERGENCY NOTIFY	RELATIONSHIP	PHONE

PERSON FINANCIALLY RESPONSIBLE IF NOT PATIENT:

NAME	ADDRESS CITY STATE ZIP CODE	PHONE
DATE OF BIRTH	SOCIAL SECURITY NO.	EMPLOYER

Insurance: Please list the subscriber of the policy if other than the patient. List your primary insurance first.

PRIMARY_____ **Policy #**_____ **Group #**_____

Subscriber_____ **Subscriber's Date of Birth**_____

Subscriber's Employer_____

SECONDARY_____ **Policy #**_____

Group Subscriber_____ **Subscriber's Date of Birth**_____

Subscriber's Employer_____

NO-SHOW POLICY

If it is necessary to cancel an appointment, patients are required to call at least 24 hours before their appointment time. Patients who do not keep their scheduled appointment will be considered a "no show". Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a "no show". A patient determined to be a "chronic no show" may be discharged from the practice.

NOTICE OF PRIVACY PRACTICES

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

Our Notice of Privacy Practices is always available on our website: **rockymountaineyecenter.com,** posted in our offices, and in printed form at the front desk for your reference.

Signature: _____ **Date:** _____