



**INTEGRATED**  
OCULAR PROSTHETICS, INC.

**Registration:**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you here of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

**Physician**

**Family Physician**

**Referring Physician**

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Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to Integrated Ocular Prosthetics, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature <b>X</b>	Signature Date	Phone	Email
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**Please attach all pertinent insurance ID Cards for photocopying.**