

**RASHID & RICE EYE ASSOCIATES, PLLC
REGISTRATION FORM - Please Print**

PATIENT INFORMATION:

DATE: _____

NAME: _____
(First) (Middle) (Last)

Street Address: _____

City, State, Zip: _____ Drivers License# _____

Social Security#: _____ Date of Birth: _____ Age: _____

Sex: M _____ F _____ Home Phone: _____ Work Phone: _____

Marital Status: M _____ S _____ W _____ Email: _____ Cell Phone: _____

Emergency Contact: Name _____ Phone : _____

Employer Name: _____

Employer Address: _____

Spouse Name: _____

Spouse Employer: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

***Policyholder: _____ Date of birth of policyholder if different from insured _____

Secondary Insurance: _____ Policy #: _____

***Policyholder: _____ Date of birth of policyholder if different from insured _____

ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF APPOINTMENT

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

List any known allergies: _____

Are you a resident of a skilled nursing Facility? _____ . If yes - Name of Facility _____

IF PATIENT IS UNDER 18, LEGAL GUARDIAN TO COMPLETE #s 1-7 BELOW

1.) Name: _____
(First) (Middle) (Last)

2.) Relationship to Patient: _____

3.) Address: _____

4.) Social Security: _____ Date of Birth: _____

5.) Employer Name; _____

6.) Employer Address: _____

7.) Employer Phone #: _____

Notice:

1. The Physician/Owners of this practice also own Mockingbird Optical Shop San Antonio TX.
2. The Physician/Owners of this practice also own a partial interest in Specialty Surgery Center, San Antonio, TX.

AUTHORIZATION (ALL PATIENTS MUST SIGN):

I understand that I am responsible for payment of any services rendered to me or my dependent provided by this office. I understand that a collection fee may be charged for accounts that require collection procedures. I authorize payment of insurance benefits to be paid directly to the party who accepts assignment/participation with my insurance company. I also authorize the physician to release any information required to process this claim.

Date

Signature of Patient or Legal Guardian

MEDICARE LONG -TERM AUTHORIZATION (PATIENTS COVERED BY MEDICARE MUST SIGN):

I request that payment of authorized Medicare benefits be made either to Edward R. Rashid, M.D., or Robert A. Rice, M.D., or Julie C. Tsai, M.D. or William J. Flynn M.D., or Mark G. Carolan, O.D. for any service furnished me by the above doctors.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents, any information needed to determine these benefits or the benefits payable for related services.

Date

Signature of Patient or Legal Guardian

SECONDARY INSURANCE AUTHORIZATION (PATIENTS WITH SUPPLEMENTAL INSURANCE TO MEDICARE MUST SIGN):

I request that payment of authorized secondary insurance benefits be made on my behalf to Edward R. Rashid, M.D., or Robert A. Rice, M.D., or Julie C. Tsai, M.D. or William J. Flynn M.D., or Mark G. Carolan, O.D. for any service furnished me. I authorize any holder of medical information about me to release to my secondary insurance carrier or plan, or heir agents, any information needed to determine these benefits or benefits payable for related services.

Date

Signature of Patient or Legal Guardian

I understand, that in case of an emergency, I may have to see the physician on call in San Antonio, Texas, if I live outside the San Antonio area.

Date

Signature of Patient or Legal Guardian

RASHID & RICE EYE ASSOCIATES, PLLC
Edward R. Rashid, M.D. ĩ Robert A. Rice, M.D.
Julie C. Tsai, M.D. ĩ William J. Flynn M.D. ĩ Mark G. Carolan, O.D.
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