



**Patient Registration Form**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Divorce  Widowed      Gender:  Male  Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Employer: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Occupation: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Responsible Party:  Self  Other: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Please check the one that applies to how you heard of us.		
<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Newspaper	<input type="checkbox"/> ER
<input type="checkbox"/> Web Site	<input type="checkbox"/> Other Publication	<input type="checkbox"/> Relative / Friend Name: _____
<input type="checkbox"/> Naples Daily News	<input type="checkbox"/> Radio which one? _____	<input type="checkbox"/> Direct Mail
<input type="checkbox"/> Other	<input type="checkbox"/> Other	
Workers Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident: _____

Claim #: \_\_\_\_\_ Contact Name: \_\_\_\_\_ PH: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

I, the undersigned authorize payment of medical benefits to Michael J. Collins, Jr., M.D. FACS and Collins Vision for any services furnished to me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I have received / declined a copy of Collins Vision Notice of Privacy Practices and understand that a copy of the Privacy Practices may be given to me upon request.

\_\_\_\_\_  
Patient, Parent or Guardian Signature

\_\_\_\_\_  
Date

**Medicare Lifetime Signature on File: (Medicare Patients Only)**

I request that payment of authorized Medicare Benefits be made on my behalf to Michael J. Collins, Jr., M.D.FACS and Collins Vision for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date