Talamo Laser Eye Consultants 1601 Trapelo Rd, Sute 184 Waltham, MA 02451 (781) 890-1023

PATIENT REGISTRATION

Mr. Ms.
Dr. Mrs. _____
(circle one) Last Name First Name Middle Name

☐ MALE ☐ FEMALE DATE OF BIRTH _____/_____/_____ AGE _____

OCCUPATION: _____ SOCIAL SECURITY # _____-_____-_____
PERMANENT ADDRESS:

_____
Street City State Zip

LOCAL ADDRESS:

_____
Street City State Zip

TELEPHONE:

_____(_____)_____(_____)_____(_____)_____
Home Work Local

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Unknown

For insurance purposes, marital status is required. If you do not wish to disclose marital status, please check 'Unknown'

PRIMARY CARE PHYSICIAN: _____ PHONE: (_____)_____

ADDRESS: _____

REFERRING PHYSICIAN: _____ PHONE: (_____)_____

ADDRESS: _____

INSURANCE INFORMATION

☐ No Medical Coverage

☐ Medical Coverage provided by:
Insurance Carrier: _____
Subscriber Name: _____
Subscriber Date of Birth: _____ Relationship to Patient: _____
Insurance ID Number: _____

To ensure accurate billing, please have your insurance card available at the time of your appointment. A copy will be retained in your medical record.

REFERRAL WAIVER

My insurance may require a referral/authorization. I am aware that I do not have a referral from my Primary Care Physician (PCP) for my office visit. I further understand that if I do not contact my PCP to obtain a referral, I will be financially responsible for any charges denied by insurance for lack of referral/authorization. I am responsible for contacting the billing department at (781) 890-1023 to provide the referral number.

Signature of Patient: _____ Date: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of Patient: _____ Date: _____