Robert L. Stephenson, M.D.
Robert C. Erickson, M.D.
Timothy P. Page, M. D.
Maria Jancevski, M.D.

PATIENT REGISTRATION FORM

Please Print

Patient Name _____ **Social Security #** _____

Address_____

City_____ **State**_____ **Zip**_____

Home phone_____ **Cell phone**_____

Email _____

Date of Birth_____/_____/_____ **Sex - M F** **Marital Status – M S W D**

Primary Language _____ **Patient declines**

Race _____ **Patient declines**

Ethnicity_____ **Patient declines**

Employer Name_____ **phone**_____

Primary Care Physician_____**Phone**_____

INSURANCE CARDS AND DRIVERS LICENSE OR STATE ID MUST BE PROVIDED TO THE FRONT DESK

My signature authorizes Oakland Ophthalmic Surgery to discuss my treatment and financial status with my immediate family members and/or individuals name YES_____ NO_____

Individuals Names – 1._____ 2._____

Authorization: I authorize treatment of my ophthalmic condition by the physicians of Oakland Ophthalmic Surgery, P.C. I authorize the release of any medical or other information necessary to file a claim with my insurance company (including Medicare) and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME to my physician, or the group Oakland Ophthalmic Surgery, P. C. I understand that I am financially responsible for any service that is not a benefit or any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Patient or Responsible Party Date