Comprehensive Eye Care of New England
Laurie J. Elgas, OD – Sally Carlos, OD

Patient Registration Form

PATIENT INFORMATION – Please Print Date:_____

Name:_____ Date of Birth _____Sex: M F

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____ Cell Phone:_____

E-mail Address: _____ **Preferred Number:** ☐ **Home** ☐ **Cell**

PCP Name/Phone: _____Pharmacy Name/Phone: _____

RESPONSIBLE PARTY'S INFORMATION- Please Print ☐ ***Same as above***

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

EMERGENCY CONTACT INFORMATION – Please Print

Name:_____ Phone Number_____

REFERRAL INFORMATION – Please Print
How did you learn about our office? (circle one)
Relative Friend Doctor Referral HMO/Insurance Newspaper Other:_____

Who may we thank for referring you to our office? _____

My signature below will verify that I am being offered a copy of the Notice of Privacy Policy stating my privacy rights and how they are handled at this office. A copy of the policy can be obtained on-line at www.drlaurieelgas.com

I hereby authorize any necessary medical treatment by Dr. Elgas/Carlos and further authorize Dr. Elgas/Carlos to file a claim to my Insurance(s) providing I have coverage for the services rendered. I understand that I am responsible for my bill and any collection fees made necessary to collect payment of services and/or products provided in the event that I do not have the required coverage or the insurance claim is denied. I understand that I am responsible for obtaining any necessary referrals and understand that I may be responsible for payment if a referral is not obtained. I further authorize the office of Dr. Elgas/Carlos to release or obtain any required medical information from my primary care physician, specialist or any medical/insurance facility required for continuing medical care and /or processing of insurance claims.

Patient Signature: _____Date:_____
(If MINOR, a parent/guardian MUST sign)

We are required to request the following information – Answering is OPTIONAL

Preferred Language	***Race***	***Ethnicity***	***Communication Preference***
___*English*	___*American Indian/Alaskan Native*	___*Hispanic/Latino*	___*Telephone*
___*Portuguese*	___*Asian*	___*Native Hawaiian*	___*Postal (Mail)*
___*Spanish*	___*Black/African American*	___*Not Hispanic or Latino*	___*email*
___*Other*_____	___*Hispanic*		
	___*Native Hawaiian/Other Pacific Island*		
	___*White*		