BRISTOL COUNTY EYE CARE
CARE YOU CAN COUNT ON

1180 HOPE STREET
BRISTOL RHODE ISLAND 02809
(401) 253-9900
BRISTOLCOUNTYEYECARE.COM

# Patient Registration Form

-You will need to pay for your office visit or co-pay today. We do not bill for co-payments or office visits.
-We will file your insurance claim if you have Medicare, Medicaid, Blue Cross/Blue Shield, Blue Chip, United Health or Cigna.

**PLEASE PRINT**

Circle One: Mr. Mrs. Ms. Dr. Rev. Sister Sex: M F DOB: _____/_____/_____

Name: _____
*First* *M.I.* *Last*

Address: _____
*Street* *City* *State* *Zip*

Home Phone: _____Work Phone: _____Cell Phone: _____

Email: _____ Social Security #: _____

Employed By: _____ Occupation: _____

Employer's Address: _____

Marital Status: S M Spouse's Name: _____

Primary Insurance: _____ Policy #_____

Subscriber's Name: _____ Subscriber's Employer: _____

Secondary Insurance: _____ Policy #:_____

Subscriber's Name: _____ Subscriber's Employer: _____

Emergency Contact: _____
*Name* *Phone*

How did you hear about us? _____

I request that payment of authorized Medicare benefits or other insurance be made on my behalf to Dr. Carl A. Sakovits for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date: ____ /_____/_____