211 McAuley Court, Hot Springs, AR 71913 * 205 McAuley Court, Hot Springs, AR 71913
Offce: 501-624-0609 Fax: 501-624-6191 * Office: 501-624-6330 Fax: 501-624-1060
www.holteye.com

Adult Patient Registration Form

This clinic accepts assignment on Medicare and Medicaid patients. All patients are expected to pay for non-covered services, their portion and the applicable copay on the date of service unless prior arrangements have been made. Thank you for your cooperation.

Date of Completion: ________________ Date of Birth: ___________ Age: _____ Marital status: ________________

PATIENT: ______________________________ ☐ Male ☐ Female Race: ______________

Social Security #______________________________ Ethnicity: ____________ Language: ______________

Address: ____ Phone: ______________________

City: __________________ State: __________ Zip: __________

Email Address: ____ Cell Phone: ______________________

Patient's employer: ____ Work Phone: ______________________

Emergency Contact: ____ Phone: ______________________

Relationship to patient: ____________________________________ Language: ______________________

Primary Insurance: ____ Secondary Insurance: ______________________

Does your insurance require a referral? YES or NO Do you have a Co-Pay? Yes or No

Vision Plan: ______________________________ Prescription Drug Coverage: ______________________

Are you allergic to Latex: YES or No Please explain: ______________________________

Are you allergic to any Medications: YES or No If YES, please list them below:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

By signing this form, I hereby authorize:

☐ The release of any information concerning my exam or treatment for insurance purposes only.

☐ Payment directly to the physician.

☐ I have received / or was offered a copy of the clinic's Notice of Privacy Practices(NOPP) that became effective April 14, 2003 and was revised on September 23, 2013.

☐ I do not grant, ☐ I grant physician and staff to discuss my protected health information/personal information with anyone except as allowed by the HIPPA regulations as explained in the (NOPP), and to person(s) listed below:

Name	Phone	Relationship

NOTE: Please read the four statements above then check off the ones you are in agreement with. Please sign and date below, if applicable. You can refuse to sign this acknowledgement.

X______________________________ Today's date: ______________________

Your Signature Here