Wallace Eye Center
211 McAuley Court
Hot Springs, AR 71913

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.

Patient's name: _____ Date of Birth: _____
First Middle initial Last Age: _____

Address: _____
Street or P.O. Box City State Zip code

Telephone:( )_____ Cell: ( )_____ Male ☐ Female ☐
If you want us to communicate with you via email please provide your address _____
Social security number (optional) _____
Patient's employer:_____ Address: _____

Work Telephone ( ) _____ Extension _____

Spouse: _____ Spouse's employer: _____
(parent, if patient is a child)

Spouse/Parent daytime telephone: ( )_____ Extension _____

Please provide us with the name and telephone number of a friend or relative at a different address that we can contact in the event we are unable to reach you.
Name: _____ Telephone: _____

Insurance Information: Please provide us with current insurance card(s) so that we can make copies. We also file your coinsurance. If we have not heard from your coinsurance within two months after filing you are responsible for payment.
If your insurance is under your spouse or under a parent's name please complete the following:
Insured name: _____ Date of birth: _____ Relationship _____

I hereby authorize the release of any information concerning my exam or treatment for insurance purposes only.

X _____

I hereby authorize payment directly to the physician.

X _____

Today's date: _____

Please read the statements above and sign in all both places if applicable.

Form revised:April 14, 2003
June 15, 2004