Staten Island Ophthalmology (SIO)
Academic Eye Center (AEC)
John S. Kung, MD, FAAO, FICS

PATIENT REGISTRATION FORM

Patient Name: _____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____
Month Day Year

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Sex: M____ F____

If Student: Full Time or Part Time Name of School:_____

Referred by: _____ Marital Status: _____

Primary Care Physician: _____ Phone Number: _____

Insurance Information: (Please present your insurance card at the time of check in)

Primary:	**Secondary:**
Insurance Name: _____	Insurance Name: _____
Insurance Address: _____	Insurance Address: _____
Name of Subscriber: _____	Name of Subscriber: _____
Subscribers ID Number: _____	Subscribers ID Number: _____
Social Security # of subscriber: ___ -- ___ -- ___	Social Security # of subscriber: ___ -- ___ -- ___
Date of Birth of Subscriber: ____/____/____	Date of Birth of Subscriber: ____/____/____
Employer Name: _____	Employer Name: _____
Employer Address: _____	Employer Phone: _____
Relationship of Patient to Subscriber: _____	Relationship of Patient to Subscriber: _____

Other family members that are patients in this office: _____

In Case of Emergency, who should be notified? _____ Phone: (_____) _____-_____

I understand that I am financially responsible for all charges for service to me including the balance remaining after payment of possible insurance benefits, and that a finance charge of 1.5% per month will occur on my unpaid balance older than 30 days.

Signature: _____ Date: _____

I authorize the release of medical information to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ Date: _____

Parent or Responsible Party (if different from patient) Relationship to Patient: _____