Westwood Ophthalmology Associates P.A.
300 Fairview Avenue
Westwood, NJ 07675

PATIENT REGISTRATION FORM

First Name	MI	Last Name	Age	Sex: ☐M ☐F
Home Address		Apt #	Marital Status: ☐S ☐M ☐D ☐W	
City		State / Zip	DOB	
Primary # ☐Home ☐Mobile		Secondary # ☐Home ☐Mobile	Work #	
SS#	Driver's License #	E-Mail Address		
Patient Employer Name, Address/Occupation				
Financially Responsible Persons Address (if different from patient)				
Is patient residing in a Skilled Nursing Facility / Rehabilitation Center? _____ Yes _____ No				
If yes, name and address of facility:			Phone #	
Emergency Contact Name	Relationship		Phone #	
Referring Physician			Phone #	
Primary Care Physician			Phone #	

IF PATIENT IS UNDER AGE 18 PLEASE COMPLETE (WHO IS RESPONSIBLE FOR THIS ACCOUNT)

Mother's Full Name	SS#	DOB	Home #	Cell #
Mother's Employer	Work Phone # and Ext		Home Address If Different Than Above	
Father's Full Name	SS#	DOB	Home #	Cell #
Father's Employer	Work Phone # and Ext		Home Address If Different Than Above	

INSURANCE INFORMATION: Irene A.Tran, OD is the ONLY doctor who participates in some vision plans. We will only submit claims for Dr. Tran's patients to vision plans. Please initial verifying that you acknowledge this statement.

NAME OF VISION PLAN: _____ **Patients Initials** _____

Primary Insurance	Policy Holder Name	DOB	Sex: ☐M ☐F
Address			
ID #	Group #	Effective Date	
Secondary Insurance	Policy Holder Name	DOB	Sex: ☐M ☐F
Address			
ID #	Group #	Effective Date	

FINANCIAL POLICY STATEMENT

Welcome to Westwood Ophthalmology Assoc., PA, we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will submit your claim. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third party collector, you agree to pay an additional 30% of the balance or $50, whichever is greater. A return check fee of $35 will be assessed if your check is returned by your bank.

Patient's Signature **Date**

PATIENT AUTHORIZATION

I hereby authorize Westwood Ophthalmology Assoc., PA to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and or any other insurance company be made directly to Westwood Ophthalmology Assoc., PA. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare part B benefits.

Patient's Signature **Date**