BROWN
EYE CARE ASSOCIATES
Ophthalmology and Ophthalmic Surgery

Robert H. Brown, M.D
R. Stephen Brown, M.D.
Christopher D. Brown, M.D.
Andrew C. Brown, M.D.

PATIENT REGISTRATION INFORMATION

First Name:_____ Last Name: _____ Middle Initial: _____

Date of Birth:_____ Social Security #_____ - _____ - _____ Age: _____

Gender: □ Male □ Female Marital Status(circle one):Single/Married/Divorced/Separated/Widowed

Address:_____ Apt#:_____City: _____

State: _____Zip Code:_____Home Phone:_____Cell Phone: _____

Email: _____ Spouse/Guardian's Name (if applicable): _____

Primary Care Physician:_____

Pharmacy Name/Phone: _____

Primary Language: _____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ UNKNOWN
☐NOT HISPANIC OR LATINO ☐DECLINE TO PROVIDE

RACE: ☐ AMERICAN INDIAN OR ALASKAN NATIVE
☐ ASIAN ☐ BLACK ☐ WHITE ☐ UNKNOWN
☐HAWAIIAN NATIVE OR PACIFIC ISLANDER
☐ DECLINE TO PROVIDE

Referred by: _____

Patient's Employer: _____ Business Address/Phone: _____

In case of emergency, who should we contact?_____Phone: _____

Is this a Workman's Compensation Case? ☐Yes ☐No

Complete if Patient is Under 18 years/Student:

Other Parent/Guardian: _____ Home Phone:_____

Address (if different from patient's) _____ Work Phone: _____

City _____ State _____ Zip Code_____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and any other health plans to Brown Eye Care Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services rendered that are considered out of network or any balance that is not covered by my insurance carrier. I authorize the use of this signature on all insurance submissions. I authorize Brown Eye Care Associates to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Signature of Responsible Party:_____Date:_____