

Barenburg Eye Associates

Patient Registration

Park

Dundalk

Ellicott City

Woodholme

Garwyn

Dr. Mark Gordon
Dr. Shoshana Cohen
Dr. Ross Fischer
Dr. Brian Granek

Dr. Harold Katz
Dr. Joshua Gordon
Dr. Nina Gelfond
Dr. Stephen Hameroff

Patient Name (Last, First, Middle)

Mr./Mrs./Miss/Dr.

Home Address		City, State, Zip	
Home Phone		Work Phone	
Patient's Occupation Student		Social Security Number	
Date of Birth	Age	Sex	Marital Status S M D W
Patient's Employer		Referred By	
Insurance Information			
Name of Primary Insurance		Secondary Insurance	
Address		Address	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Employer		Policy Holder's Employer	
Policy Holder's Date of Birth	Sex	Policy Holder's Date of Birth	Sex
Insurance Number		Insurance Number	
Policy Holder's SS #		Policy Holder's SS#	
Patient's Authorization			
<p>I hereby authorize BARENBURG EYE ASSOCIATES to apply for benefits on my behalf for covered services rendered and request that payment be made directly to BARENBURG EYE ASSOCIATES. I certify that all the information in regards to my insurance is correct and further authorize the release of any necessary information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing. I certify that all the information provided on this form is valid and will accept any and all responsibility caused by incorrect information.</p>			
Patient or Guardian Signature		Date	