Barenburg Eye Associates Patient Registration

❍ **Park** ❍ **Dundalk** ❍**Ellicott City** ❍**Woodholme** ❍ **Garwyn**

Dr. Mark Gordon
Dr. Shoshana Cohen
Dr. Joshua Gordon
Dr. Rita Vekker
Dr. Harold Katz
Dr. Jonathan Ekedahl
Dr. Ross Fischer

Patient Name (Last, First, Middle) (Mr./Mrs./Miss/Dr.)

Home Address		City, State, Zip	
Home Phone	Work Phone	E-mail Address (if available):	
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

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.

Patient or Guardian Signature	Date