

Registration :

Valarie Overton MD PLLC

| | | | | |
|------|------------|----------|----------|--------------|
| Date | Account ID | Chart ID | Other ID | Internal Use |
|------|------------|----------|----------|--------------|

Patient Information

| | | | | | | | |
|-------------------|------------|----------|-------------------------|-------------------------|-----------|----------------|-------------------|
| Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Age | Social Security # |
| Address | | | Home: | How did you hear of us? | | | |
| Address 2 | | | Work: | | | | |
| | | | Cell: | | | | |
| | | | Email: | | | | |
| City | State | Zip Code | Employer Name & Address | | | Occupation | |
| Emergency Contact | Phone | | Pharmacy | | | Pharmacy Phone | |

| | | |
|------------------|-------------------------|----------------------------|
| Physician | Family Physician | Referring Physician |
|------------------|-------------------------|----------------------------|

| Medical Insurance | Name & Address | Policyholder | Relationship | Copay | Policy ID | Group ID |
|-------------------|----------------|--------------|--------------|-------|-----------|----------|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |

Guarantor (Person to be billed, if different than patient)

| | | | | | | |
|--------------|------------|----------|-------------------------|----------------|-----------|-------------------|
| 1 Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security # |
| Address | | | Home: | Work: | Email: | |
| City | State | Zip Code | Employer Name & Address | | | Occupation |
| 2. Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security # |
| Address | | | Home: | Work: | Email: | |
| City | State | Zip Code | Employer Name & Address | | | Occupation |

HIPAA Approved Contacts

| | | | | | | |
|--------------|------------|--------|--------|-----------|-------------------|--------------|
| 1. Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
| Address | | City | State | Zip Code | Home: | Cell: Work: |
| 2. Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
| Address | | City | State | Zip Code | Home: | Cell: Work: |

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and and assign directly to Valarie Overton MD PLLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information, including prescription drug information, for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations. I agree to pay for refraction, which is the test performed by the doctor to determine my eyeglass prescription, if I choose to have it done and it is not covered by my insurance.

| | | | |
|-----------|----------------|---|-------------------------------|
| Signature | Signature Date | Valarie Overton MD PLLC 688 White Plains Rd, Ste 224 Scarsdale, NY 10583 | Phone: 914-725-5556 Email: |
| X | | | |

Please attach all pertinent insurance ID cards for photocopying.