

Peter S. Levin, M.D.

Ophthalmic Plastic Surgery

525 South Drive, Suite 101
Mountain View, CA 94040
(650) 964-9600

Patient Registration. Welcome to our office.

Please print and fill out completely. Please provide insurance cards to photocopy.

Name: _____ Birth Date: ___/___/____ Sex: _____
last first middle

Social Security #: _____ - _____ - _____ Cell phone (provide only if OK to use) _____

Home address: _____
Street City State Zip

Home phone: () _____ Work phone: () _____

We will respect your confidentiality. May we leave messages at home () yes () no. At work () yes () no.

Emergency contact person: _____ Phone: _____

How were you referred to Dr. Levin? _____ Telephone: () _____

Address of referring individual: _____

Primary Care physician: _____ Telephone: () _____

Primary Care physician address/city/zip: _____

Employer: _____

Spouse/Parent: _____

Spouse's/Parent's Employer: _____

Primary Insurance Company: _____ Subscriber name: _____

Insurance I.D. #: _____ Group number: _____

Secondary Insurance Company: _____ Subscriber name: _____

Insurance I.D. #: _____ Group number: _____

PLEASE SIGN BELOW AND RETURN TO THE FRONT DESK

I, the undersigned, have insurance coverage and assign directly to Peter S. Levin, M.D. all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that some insurance plans have "preferred" panels of physicians or require prior authorization prior to seeing physicians. I understand that I am responsible for payment of fees if authorization has not been obtained for whatever reason. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date _____ Signed _____

All Medicare patients must sign lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Peter S. Levin, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made, and authorizes release of information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

Date _____ Signed _____

The evaluation that you receive is specialized and is limited to your facial plastic problem. I am aware that Dr. Levin is not providing an "eye examination" and that this visit does not replace your need for an eye exam.

Date _____ Signed _____