Registration :										No	orth (Centr	al Ev	ve Ass	sociates In
Date	Account ID		C	Chart ID					Other ID				Internal Use		
Patient Information															
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Guarantor (Person to b	e billed, if differe	ent the	an pati	ent)											
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HIPAA Approved Contac	cts														
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2.Last Name	First Name	<i>Management</i>	Mic	Middle Gend		Bir	Birthdate		Social Securi		rity #			Relations	ship
Address	City	!				State	Zip Co	ode	Home:	»···	Cell:			Work:	***************************************
Patient's or Authorized	Person's Signat	ure				.00000000000000000000000000000000000000					8		1		
I the undersigned give my at payable to me for services repaid by insurance. I hereby a signature on all my insurance	authorization to treat a rendered. I understar authorize the doctor	and ass and that r to relea	t I am ult ease all i	timately informa	y fina ation i	ancially neces	y respo ssary to	onsible o secu	e for all ure the p	l appro	ved an	d covere	ed cha	arges wh	ether or not
I acknowledge receipt of the of treating me, obtaining pay	yment for services re	endered	d to me,								close r	ny heal	th info	rmation	for purposes
Signature X	Signa	nature Da	ate	.0000000nnhywn		278	North Central Eye Associates Inc. 278 Benedict Avenue, Suite 300 Phone: 419-668-329 Norwalk, OH 44857 Ema							68-3295 Email:	
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