

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ (CIRCLE ONE) FEMALE MALE

PATIENT'S S.S.# _____ - _____ - _____

NAME OF EMPLOYER _____ WORK PHONE _____ X _____

MARITAL STATUS - (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED

NAME OF SPOUSE _____ SPOUSE'S SS# _____ - _____ - _____

EMERGENCY CONTACT PERSON _____ PHONE# _____

**PATIENT'S FAMILY DOCTOR'S NAME _____

FAMILY DOCTOR'S PHONE# AND/OR ADDRESS _____

**DID A DOCTOR RECOMMEND THAT YOU SEE US REGARDING AN EYE PROBLEM OR OTHER HEALTH CONDITION? IF YES - DOCTOR'S NAME _____

.....
WE NEED A COPY OF YOUR INSURANCE CARD TO INSURE THAT WE FILE YOUR INSURANCE PROPERLY. THANK YOU.

*Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amounts, co-insurance, or any other balance not paid for by insurance.

INTEREST MAY BE ADDED TO OVERDUE BALANCE

*I request that payment of authorized Medicare benefits be made either to me or on m behalf to Eye Physicians and Surgeons, S.C. for any services furnished me by that provider. I authorized 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.

*This authorization is in effect until I choose to revoke it. I understand that I am financially responsible for all charges whether or not paid by said insurance.

*If you're a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement

SIGNED X _____ TODAY'S DATE _____

IF UNDER AGE 18 - PARENTS/GUARDIANS NAME _____