PLEASE TYPE or PRINT

PATIENT NAME_____ _____ DATE OF BIRTH _____
Last First Middle initial

ADDRESS_____

CITY _____ STATE_____ ZIP _____

HOME PHONE (___) _____ CELL PHONE (___)_____

WORK PHONE (___) _____ x _____ E-MAIL _____

PATIENT'S S.S. #_____ (check one) ❑ FEMALE ❑ MALE

NAME OF EMPLOYER _____ OCCUPATION _____

MARITAL STATUS – (check one) ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

NAME OF SPOUSE _____SPOUSE'S SS# _____ DOB _____

EMERGENCY CONTACT PERSON _____ PHONE# _____

** PATIENT'S FAMILY DOCTOR _____ PHONE# _____

FAMILY DOCTOR'S ADDRESS_____

** WERE YOU REFERRED TO OUR OFFICE: (check one) ❑ YES ❑ NO

REFERRED BY: _____

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 BALANCES OVER 90 DAYS OLD at a rate of 1% per month from date of service.

*I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eye Physicians & 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 are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

*Regarding routine vision coverage (i.e. Eyemed, VSP, VCP, Davis Vision, etc.), these types of coverage will be billed if there is no medical finding during your exam. If however, during your exam, a medical diagnosis is found, the exam will be considered medical and as such will be submitted to your Medical insurance.

SIGNED X _____ TODAY'S DATE _____

IF UNDER AGE 18 – PARENTS/GUARDIANS NAME _____

ADDRESS _____ CITY _____ STATE_____ZIP_____

Clear Form Please complete this form, print it, sign it and bring it with you to your appointment. Save Print