Patient's Full Name: ___________________________________ **Date of Birth:** ____________

(Last) *(First)* *(Middle)*

Last four of Social Security # ***-**__________

Occupation: _____________________________________ Employer: ____________________________________

Please circle: Male Female

Child Single Married Widowed Divorced

Race: African American Asian Caucasian Hispanic or other: ___________________

Mailing Address: _______________________________ City: ______________ State: ______ Zip: __________

Best Contact Phone Number (____) ______________________ Home Cell Work

Second Contact Phone Number (____) ____________________ Home Cell Work

E-Mail: ____

Emergency Contact Person Name: _______________ Relationship: ___________ Phone (____) ____________

Spouse/Guarantor Name: _________________________Last four S. S. #: ***-**________ DOB: ___________

Primary Care Physician: ______________________ Facility: ________________ Phone (____) ____________

Referring Physician: _________________________ Facility: ________________ Phone (____) ____________

We need a copy of your insurance card(s) to ensure that we file to your insurance company properly. 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. Copays & refraction fees are due at the time of visit. Late fees may be added to balances of 90 days old at a rate of 1% per month from date of service. Regarding routine vision coverage 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.

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 to me by that provider.

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 authorize Eye Physicians & Surgeons, S.C. to view/import my medication history when electronically prescribing medications. This authorization is in effect until I choose to revoke it.

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

I have been offered and/or received a copy of HIPAA notice of Privacy Practices and understand.

SIGNED ____ TODAY'S DATE__________________

IF UNDER AGE 18 – PARENTS/GUARDIANS NAME____

ADDRESS_________________________________CITY_______________________STATE________ZIP________

In front of: (Staff at EPS) ____TODAY'S DATE: ______________