PATIENT INFORMATION

PRIMARY CARE DOCTOR_____PHONE #_____FAX #_____

PRIMARY NAME_____ BIRTHDATE_____

SOCIAL SECURITY #_____ MARITAL STATUS ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE #_____ CELL #_____WORK#_____

MAY WE LEAVE MESSAGES ON PHONE NUMBERS PROVIDED ABOVE? ( ) YES ( ) NO

STREET ADDRESS_____ APT #_____

CITY_____ STATE_____ZIP_____

PATIENT EMAIL ADDRESS_____

DRIVERS LICENSE_____ DRIVER'S LICENSE STATE_____

EMPLOYER/SCHOOL: _____ TITLE_____ PHONE #_____

SPOUSE NAME_____ BIRTHDATE_____

PRIMARY LANGUAGE SPOKEN_____ ETHNICITY ( ) HISP ( ) NON HSP ( ) UNKNOWN

RACE ( ) ASIAN ( ) BLACK ( ) WHITE ( ) OTHER

REFERRED BY _____

NAME OF PHARMACY_____ PHONE_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME_____ FATHER'S NAME_____

EMPLOYED BY_____ EMPLOYED BY_____

PHONE # _____ PHONE # _____

PRIMARY INSURANCE INFORMATION: **SECONDARY INSURANCE INFORMATION:**

INSURANCE CO_____ INSURANCE CO_____

ADDRESS_____ADDRESS_____

CITY/STATE/ZIP_____ CITY/STATE/ZIP_____

PHONE #_____ PHONE #_____

I.D. #_____ I.D. #_____

INSURED NAME OR #_____ INSURED NAME OR #_____

INSURED SOCIAL SEC. #_____ DOB_____ INSURED SOCIAL SEC. #_____ DOB_____

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD

PHYSICIAN'S RELEASE & AGREEMENT

I request that payment of authorized Medicare/insurance benefits be made either to me or on my behalf to Eye Surgeons & Consultants for any services furnished to me by the physician or supplier. I authorize any holder of medical information to release to the Heath Care Financing Administration and it agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on item 9 of the HCFA-1500 claim form or elsewhere on other approved 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, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

SIGNATURE (Patient's parent if minor)_____ Date _____