



WELCOME TO OUR OFFICE

TODAY'S DATE _____

Patient's Name _____
(Last) (First) (MI)

Address _____

City _____ State _____ Zip _____

Local Phone _____ Social Security # _____

Employer _____ Work Phone _____

Date of Birth _____ Name of Spouse or Parent _____

Ins Policy holder's Name _____ Date of Birth _____

Insurer's Social Security _____ Ins ID# _____

Referred by _____ E-mail Address _____

PLEASE NOTE: PAYMENT IS EXPECTED AT TIME OF SERVICE

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to Eye Center Inc. for any services rendered to me by any doctor of the Eye Center Inc.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, copays, coinsurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided.

Signature of Patient or Legal Guardian

Date

Release of Information

May we leave personal medical information on your answering machine at home or on your cell phone voice mail?

Circle: Yes No If yes which one?

Do you give our office permission to discuss your medical information with anyone?

If yes, please provide their name and phone number below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature of Patient or Legal Guardian

Date