Welcome

EYE CENTER, Inc.

TODAY'S DATE _____

PATIENT'S INFORMATION

Last Name _____ First Name _____ Middle Inital _____ ☐ Female ☐ Male

Address _____

City _____ State _____ ZIP _____

Home Telephone _____ Mobile Telephone _____ Social Security # _____

Employer _____ Work Telephone _____

Date of Birth _____ Name of Spouse or Parent _____

Email Address _____ Referred by _____

MY INSURANCE AND FINANCIAL INFORMATION (Please present your insurance card at time of service.)

Insurance Policy Holder's Name _____ Date of Birth _____

Insurance Policy Holder's Social Security # _____ Insurance Identification Number _____

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, co-pays, co-insurance 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 MY MEDICAL INFORMATION

May we leave personal medical information on your answering machine? ☐ Yes ☐ No Telephone _____

May we leave personal medical information on your cell phone voice mail? ☐ Yes ☐ No Telephone _____

I give representatives from Eye Center, Inc. permission to discuss medical information with the following:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Signature of Patient (or Legal Guardian) _____ Date _____