THE EYE CENTER

Patient Name____ Date________________

First M. Last

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

Male/Female SSN____________________________ Birthdate_______________________

Address____

City____State__________ Zip__________

Home Phone ______________________________ Work Phone____________________________

Cell Phone ____________________________ E-mail Address ______________________________

Patient or parent's employer ______________________________Work Phone _________________

Business Address __________________________City____________State___________Zip_______

Spouse or parent's name______________________Employer_______________Phone___________

If patient is a student name of school/college ______________________City___________State____

Who is your primary medical doctor? ____

Person to contact in case of emergency ___________________________Phone_________________

RESPONSIBLE PARTY

Name of person responsible for this account________________________Relationship___________

Address____Home Phone __________________

Birthdate_________________ Is this person currently a patient in our office? YES NO

Employer ____Work Phone __________________

INSURANCE INFORMATION

Insurance Company _________________________ ID#________________Group #_____________

Insurance Co. Address ________________________City______________State______Zip________

Name of Insured_________________________________Relationship to Patient________________

Birthdate________________________Social Security Number ______________________________

Name of Employer____ Work Phone_______________

Do you have any additional insurance? YES NO If yes, please complete the following:

Insurance Company ___________________________ ID#_____________Group #______________

Insurance Co. Address _________________________City______________State______Zip_______

Name of Insured_________________________________Relationship to Patient________________

Birthdate_______________________Social Security Number _______________________________

Name of Employer______________________________________ Work Phone_________________

We appreciate the confidence you have expressed by selecting us as your physicians. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us. The best medical service is based on friendly, mutual understanding between the doctor and patient.

You will be provided with an itemized copy of your charges for the visits. Necessary forms will be completed to help expedite insurance carrier payments. However, all patients will be expected to pay for services at the time they are rendered unless other arrangements have been made in advance with our business office. We prefer payment prior to sending an end of the month statement, as this helps us to contain costs by saving on billing expenditures.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to The Eye Center for any services furnished me by that physician/supplier. 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 understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the physician or supplier agrees accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible for the deductible, co-insurance, co-pays and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare or other insurance company.

X____ Date________________________

Signature of patient (or parent if minor)