

Physicians Eye Clinic, Cataract & Refractive Surgery Center

PATIENT INFORMATION

NAME: _____ DATE _____
 (first) (middle) (last) ALTERNATE ADDRESS _____
 ADDRESS: _____
 CITY STATE ZIP MARITAL STATUS: **Single**
 HOME PHONE (_____) _____
 WORK/CELL PHONE _____ ALIAS _____
 EMPLOYER _____
 SOCIAL SECURITY # _____ GENDER: MALE FEMALE
 BIRTH MONTH DAY YEAR AGE PERSONAL E-MAIL ADDRESS: _____

INFORMATION ON SPOUSE OR PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE

NAME _____ SOCIAL SECURITY # _____
 (first) (middle) (last) HOME PHONE (_____) _____
 ADDRESS _____
 CITY STATE ZIP BUSINESS PHONE (_____) _____
 EMPLOYER _____ RELATIONSHIP TO PATIENT _____

RELATIVE OR FRIEND NOT LIVING WITH YOU: NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE # (_____) _____

CO-PAY _____ Co-pays are due at the time of service or are subject to a \$5.00 billing fee

INSURANCE INFORMATION	PRIMARY INSURANCE <input type="checkbox"/> MEDICAL <input type="checkbox"/> VISION <input type="checkbox"/> OTHER	OTHER INSURANCE** <input type="checkbox"/> MEDICAL <input type="checkbox"/> VISION <input type="checkbox"/> OTHER
INSURANCE NAME		
POLICY HOLDER'S NAME		
POLICY HOLDER'S EMPLOYER		
POLICY HOLDER'S SOCIAL SECURITY #		
GROUP #, MEMBER #, OR CLAIM #		
POLICY HOLDER'S ADDRESS & PHONE NUMBER IF DIFFERENT FROM PATIENT		
POLICY HOLDER'S BIRTH DATE & SEX M F		
RELATION OF PATIENT TO POLICY HOLDER		

****MEDICARE PATIENTS ONLY**
 PLEASE CHECK APPROPRIATE BOX

SUPPLEMENTAL INSURANCE IS PROVIDED BY PATIENT (MG)

SUPPLEMENTAL INSURANCE IS PROVIDED BY EMPLOYER (SP)

Release of benefits / medical information and lifetime Medicare authorization

I authorize my insurance benefits to be paid directly to Physicians Eye Clinic Cataract & Refractive Surgery Center. I am financially responsible for any balance due. I also authorize Physicians Eye Clinic Cataract & Refractive Surgery Center or my insurance company to release any information required for this claim. Fees are due at the time of my appointment unless other arrangements are made in advance.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Physicians Eye Clinic Cataract & Refractive Surgery Center including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid services and its agents any information needed to determine these benefits or benefits for related services.

SIGNATURE _____ **DATE** _____
 (SIGNATURE OF PATIENT, GUARDIAN OR PARENT IF A MINOR)