Physicians Eye Clinic, Cataract & Refractive Surgery Center

PATIENT INFORMATION

DATE ______________________

NAME: ____ ALIAS ______________________________
(first) (middle) (last)

ADDRESS: ____ (Apt #) ALTERNATE ADDRESS ______________________________

CITY ____________ STATE ______ ZIP __________ ______________________________

HOME PHONE (______) ______________________ MARITAL STATUS: SINGLE MARRIED WIDOWED OTHER

WORK/CELL PHONE ______________________ SPOUSE'S NAME ______________ DOB ________

EMPLOYER ______________________ PATIENT GENDER: MALE FEMALE

SOCIAL SECURITY # ______________________ E-MAIL ADDRESS: ______________________

BIRTHDATE: ______________________ AGE: __________

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

NAME: ____ SOCIAL SECURITY # ______________________
(first) (middle) (last)

ADDRESS ______________________ HOME PHONE (______) ______________________

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 MEDICAL VISION OTHER	OTHER INSURANCE** MEDICAL VISION 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 & Medicare 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)