## Physicians Eye Clinic, Cataract & Refractive Surgery Center

PATIENT INFORMAT	ION	
NAME: (first)		SOCIAL SECURITY #
		ALIAS
	(Apt #)	ALTERNATE ADDRESS
	STATE ZIP	
HOME PHONE ()_		E-MAIL ADDRESS:
WORK/CELL PHONE	· · · · · · · · · · · · · · · · · · ·	MARITAL STATUS: SINGLE MARRIED WIDOWED OTHER
		SPOUSE'S NAMED.O.B
WHEN POSSIBLE I PREFER	TO BE CONTACTED VIA PHONE CALL:	HOME CELL WORK □ TEXT □ EMAIL
NAME:(first) ADDRESS	(middle) (last)  STATE ZIP	SOCIAL SECURITY #  HOME PHONE ()  D.O.B
EMERGENCY INFORMA	TION: NAME:	
RELATIONSHIP		PHONE # ()
CO-PAY	Co-pays are due at the time of service or ar	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		E 401
**MEDICARE PATIENTS PLEASE CHECK APPROPRIATE		
Pologgo of bonofits / modica		wization
I authorize my insurance benefits balance due. I also authorize Phy		ract & Refractive Surgery Center. I am financially responsible for any Center or my insurance company to release any information required for
I authorize my insurance benefits balance due. I also authorize Phy this claim. Fees are due at the tin I request that payment of authoriz Cataract & Refractive Surgery Ce	to be paid directly to Physicians Eye Clinic Cata visicians Eye Clinic Cataract & Refractive Surger ne of my appointment unless other arrangements and Medicare benefits be made either to me or on enter including physician services. I authorize ar	ract & Refractive Surgery Center. I am financially responsible for any Center or my insurance company to release any information required for