

**EYE SURGEONS ASSOCIATES, P.C.**  
**New Patient Information**

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ (Last) (First) (Middle) SEX: M F

DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ PATIENT PHONE: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PATIENT/PARENT EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SPOUSE/PARENT NAME: \_\_\_\_\_

NAME OF NEAREST RELATIVE OR FRIEND (other than spouse) TO NOTIFY IN CASE OF EMERGENCY:

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

REFERRING PHYSICIAN OR OPTOMETRIST: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY NUMBER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER EMPLOYER: \_\_\_\_\_

**THIRD INSURANCE**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY NUMBER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER EMPLOYER: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE  
OF INFORMATION AND TO FILE INSURANCE**

I hereby give my permission to the doctor(s) to release any information requested by my insurance company acquired in the course of my examination and treatment. I also give Eye Surgeons Associates, P.C. the permission to file my services to my insurance company.

*SIGNATURE:* \_\_\_\_\_ *DATE:* \_\_\_\_\_

**MEDICARE SIGNATURE ON FILE**

I authorize Eye Surgeons Associates, P.C. to file Medicare for me and authorize any release of information required to file my insurance that is pertinent to my medical care. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original.

*SIGNATURE:* \_\_\_\_\_ *DATE:* \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

Our charges may exceed the usual customary amount that your insurance company will approve. You may have a contract with your insurance carrier, not with our office, therefore you are responsible for any balance not paid by your insurance. If account is referred to a attorney or collection agency, I will pay attorney fees and collection expenses.

*SIGNATURE:* \_\_\_\_\_ *DATE:* \_\_\_\_\_