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: ______________

MAILING ADDRESS: ______________________

E-MAIL ADDRESS: ______________________

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: ______________

SUBSCRIBERS'S NAME: ______________________ SUBSCRIBER BIRTHDATE: ______________

SUBSCRIBER'S EMPLOYER: ______________________

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY : ______________________

SUBSCRIBER'S SOCIAL SECURITY NUMBER: ______________________

POLICY NUMBER: ______________________ GROUP NUMBER: ______________

SUBSCRIBERS'S NAME: ______________________ SUBSCRIBER BIRTHDATE: ______________

SUBSCRIBER'S EMPLOYER: ______________________

THIRD INSURANCE

NAME OF INSURANCE COMPANY : ______________________

SUBSCRIBER'S SOCIAL SECURITY NUMBER: ______________________

POLICY NUMBER: ______________________ GROUP NUMBER: ______________

SUBSCRIBERS'S NAME: ______________________ SUBSCRIBER BIRTHDATE: ______________

SUBSCRIBER'S 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

I have been informed and provided a copy of the Eye Surgeons Associates Financial Responsibility Policies. 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 an attorney or collection agency, I will pay attorney fees and collection expenses.

*SIGNATURE:*____________________________________ *DATE:*____________________