EYE SURGEONS ASSOCIATES, P.C.
New Patient Information

DATE: _____

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

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:*_____