EYE PHYSICIANS and SURGEONS, P.C.
PATIENT INFORMATION **DATE** ______________________________

LEGAL NAME: ________________________ , ____________________________ ____________________________
Last First Middle initial

Street Address ____ **Apt. #** ______________________________

City __________________________________ **State** __________________________ **Zip** ________________________

Phone:______________________________________ **Alternate Phone:**____

SS#:__________________________ **Date of Birth:** _________________________ **Sex: M or F**

Marital Status _________________________ **E-MAIL ADDRESS** ____

Patient OR Responsible Party (If patient is a minor, parent or guardian should complete this section.)

Responsible Party: _________________________ , _______________________ _____________________________
Last First Middle initial

Relationship to patient:__________________________**Home Phone Number:** _______________________________

E-MAIL ADDRESS ____**SS#:** ___________________________________

Street Address ____ **Apt. #** _______________________________

City _________________________________**State** __________________________**Zip**_________________________

Employed? Y or N **Employer Name:** ________________________ **Work Phone:**___________ **ext.** _______
Circle one

Employer Address: ____
Street Address City State Zip

METHOD OF PAYMENT ______**Cash** ______**Check** ______**Credit Card** ______ **Ins.**

Who can we thank for sending you to our office? ____

Referring MD ____

Insurance Information
Primary Insurance Company Name: ____

Secondary Ins. Co. Name ____

*Front desk personnel will make a photo copy of your insurance card

EMERGENCY CONTACT INFORMATION
Name: ____

Address: ______________________________ ______________________________ ______________ ___________
Street Address City State Zip

Home Phone: _________________________________ **Work Phone:** ____

Relationship to patient:____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to the Physician for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature of Patient (or parent/guardian if a minor) ___________________________________ **Date** _____________