

# Patient Information

Please Print

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Last

First

MI

Sex M F (Circle One) Date of Birth \_\_\_\_\_ Marital Status (Circle One) S M W D

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ SS# \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Parent's Name (if minor) \_\_\_\_\_

Responsible Party \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

Parent's SS # \_\_\_\_\_ Parent's DOB \_\_\_\_\_ Employer \_\_\_\_\_

Referring Doctor \_\_\_\_\_

## YOUR INSURANCE

Primary Insurance \_\_\_\_\_ Policy Holder SS # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder SS # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

## YOUR MEDICAL HISTORY

Your family physician and/or practice \_\_\_\_\_

Phone \_\_\_\_\_ Is there a family history of eye disease? \_\_\_\_\_

Please list any ongoing medical problems for which you visit your doctor on a regular basis: \_\_\_\_\_

Previous surgeries, and approximate dates: \_\_\_\_\_

Drug allergies \_\_\_\_\_

Medications \_\_\_\_\_

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.** You will be required to pay your copay at each visit.
2. I understand that if my insurance requires an authorization, it is my responsibility to pay for my services in the event that an authorization has not been received prior to my date of service.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
5. Kindly give a 24 hour notice for cancellations to avoid being charged a \$25 missed appointment fee.
6. There will be a \$25 service charge for returned checks.

Signature \_\_\_\_\_