EYE PHYSICIANS and SURGEONS, P.C.

PATIENT INFORMATION

LEGAL NAME: _____ , _____ _____
Last Name First Name Middle Initial

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Phone:_____ Alternate Phone:_____

SS#:_____ Date of Birth: _____ Sex: M or F

Marital Status _____ E-MAIL ADDRESS _____

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

Responsible Party: _____ , _____ _____
Last Name First Name Middle Initial

Relationship to patient:_____ Home Phone Number: _____

E-MAIL ADDRESS _____SS#:_____

Date of Birth:_____

Street Address _____ Apt. # _____

City_____State_____Zip_____

Employer Name: _____ Work Phone:_____ ext. _____

Employer Address: _____
Street Address City State Zip

METHOD OF PAYMENT _____Cash _____Check _____Credit Card _____ Ins.

How did you hear about our practice? _____
Please indicate the persons name, internet site, advertisement, doctor's office, etc. that referred you to us.

Referring/Primary Care Physician:

Dr. _____ _____ _____
First Name Last Name Phone Number

Name of Insurance Company

Primary Insurance Company Name:

_____

Secondary Ins. Co. Name

_____

*Only need name of insurance, we will make a copy of your insurance card with the detail information

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 _____