Patient Information

Date:_____

Name:_____ Age:_____
Birth date:_____ Social Security #:_____ E-Mail:_____
Address/City/State/Zip:_____
Please Circle: Single / Married / Divorced / Domestic Partner / Widowed / Widower
Tele. #:_____
Work #:_____, Cell #:_____, Emergency #:_____

Occupation:_____ Employer:_____
Employers Address & Telephone #:_____

Name of Spouse/Partner:_____ Employer:_____
Employers Address:_____

Do you have **Vision Service Plan**? **YES** **NO.** If yes, Name/Social/Relationship of Insured.

_____

Do you have **Eye Med Insurance**? **YES** **NO.** If yes, Name/Social/Relationship of Insured.

_____

Name of **PRIMARY MEDICAL INSURANCE:** _____
Policyholder's name:_____ Date of Birth:_____ Social:_____
Name of **SECONDARY MEDICAL INSURANCE:**_____
Policyholder's name:_____ Date of Birth:_____ Social:_____
Name of **TERTIARY INSURANCE:**_____
Policyholder's name:_____ Date of Birth:_____ Social:_____

HMO Patients

All co-payments are to be paid prior to service.

In accordance with your insurance company, failure to obtain your referral, if necessary, will nullify your contract. You will, therefore, be responsible for the full amount of the visit; and payment is expected at the conclusion of your visit.

Authorization to Release Information:

I hereby authorize the doctor(s) to furnish the insured's insurance company all information which said insurance company may request concerning my claim.

Assignment of Benefits:

I hereby assign to the doctor(s) all money to which I am entitled for expenses related to the services performed from time to time, but not to exceed my indebtedness to said doctor(s). It is understood that any money received from the above named insurance company or companies over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible to said doctor(s) for charges. Should it become necessary the patient and/or responsible party agree to be personally liable for any interest, collectors cost, attorney fee and/or court costs incurred in the collection of any unpaid balance.

_____ _____

Patient Signature **Signature of Responsible Party**

Name of Physician:_____, Tele. #:_____
Address/City/State/Zip:_____

Name and Address of Pharmacy:_____