

Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Date of Birth	Age	Social Security #
Address			Home:		How did you hear about us? internet search, ad, social media, referral, etc.		
Address 2			Work:				
			Cell:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy		Phone		
Physician		Family Physician			Referring Physician		
Medical Insurance		Name & Address	Policy Holder	Relationship	Copay	Policy ID	Group ID
1							
2							
3							
Guarantor (Person to be billed, if different than patient)							
1 Last Name		First Name		Middle	Date of Birth		
Address			Phone		Email		
City	State	Zip Code	Employer Name & Address				
2 Last Name		First Name		Middle	Date of Birth		
Address			Phone		Email		
City	State	Zip Code	Employer Name & Address				
HIPPA Approved Contacts							
1 Last Name		First Name		Middle	Date of Birth		Relationship
Address		City		State	Zip Code	Phone	
2 Last Name		First Name		Middle	Date of Birth		Relationship
Address		City		State	Zip Code	Phone	
Patient's or Authorized Person's Signature							

I the undersigned give my authorization to treat and assign directly to Eye Associates, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and non-covered charges, such as refractions or contact lens services, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

X _____

Signature

Date (MM/DD/YYYY)

Please attach all pertinent insurance ID cards for photocopying