PATIENT INFORMATION

Last Name First MI

Title Mr., Mrs., Dr., Rev.,

Street Address

PO Box/ Apartment # _____

City State Zip

Home # Cell #

Work #

Email Address

EMPLOYER _____

Occupation _____

Birth Date _____/_____/_____ age _____

Sex _____M / F_____

Social Security # _____ - _____ - _____

SPOUSE/GUARDIAN _____ WORK # _____

SPOUSE'S EMPLOYER _____ CITY _____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

_____

ADDRESS AND TELEPHONE NUMBER _____

REFERRING PHYSICIAN _____ TELEPHONE # _____

ADDRESS _____ CITY _____ STATE _____ZIP _____

FAMILY PHYSICIAN _____ TELEPHONE # _____

ADDRESS _____ CITY _____ STATE _____ZIP _____

BILLING INFORMATION

Fill in if bill is to be paid by someone other than the patient

Last First MI

Title Mr., Mrs., Dr., Rev.,

Street Address

Po Box/ Apartment #

City State Zip

Home # Cell #

Work #

Is this person the patient's legal representative? YES NO

PATIENT'S LAST NAME FIRST MI

PRIMARY INSURANCE:

- Insurance Carrier_____
- Insurance Address_____
- ID Number _____Group/Policy ID # _____

Is this an employer health plan? Y/N Employment Termination Date ____/____/____

Relationship to insured _____

Insured Person _____ Insured Date of Birth _____/_____/_____
Insured Social Security Number _____ - _____ - _____

Address _____City _____State_____Zip_____

SECONDARY INSURANCE:

- Insurance Carrier_____
- Insurance Address_____
- ID Number _____Group/Policy ID # _____

Is this an employer health plan? Y/N Employment Termination Date ____/____/____

Relationship to insured _____

Insured Person _____ Insured Date of Birth _____/_____/_____
Insured Social Security Number _____ - _____ - _____

Address _____City _____State_____Zip_____
IS TODAY'S VISIT DUE TO AN INJURY? YES NO
DATE OF ACCIDENT _____/_____/_____ TYPE OF INJURY _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any information relating to all claims without obtaining my signature on each and every claim for benefits submitted on behalf of myself and/or dependents. I hereby authorize payment directly to VitreoRetinal Surgery PA for all medical and major benefits present and future for myself and/or dependents. I understand that I am financially responsible for all co-payments, deductibles, or amounts not covered by my insurance carrier.

SIGNATURE DATE