☐ NEW PATIENT
☐ CURRENT PATIENT UPDATE

FAMILY
EYE CARE
& SURGERY

## PLEASE COMPLETE ALL SECTIONS

| | | | | | |
|---|---|---|---|---|---|
| Patient Name<br>First Middle Last | | | | | Phone No. w/Area Code |
| Address<br>Street | | | City | State | Zip Code + 4 (if available) |
| Sex (please circle)<br>F M | Date of Birth | Social Security No. | Marital Status (please circle)<br>M S D Sep | Spouse Name | Spouse Date of Birth |
| Referring Physician or Primary Care (Please give full name, address & phone no.) | | | | | |
| Patient: Employer Name & Address | | | | | Work Number |
| Emergency Contact: Name | Address | | Phone Number | | Relationship to Patient |
| Financially Responsible Person (if different from patient)<br>Street | | | City | State | Zip Code + 4 (if available) |
| Financially Responsible Person: Employer Name & Address | | | | | |
| PRIMARY INSURANCE COMPANY NAME | EFFECTIVE DATE | | MEMBER'S NAME | | MEMBER'S DATE OF BIRTH |
| Primary Ins. Co. Phone No. | | Member Identification No. | | | Group Name or No. |
| Address to Submit Claims (if not on card) | | | | | |
| SECONDARY INSURANCE COMPANY NAME | EFFECTIVE DATE | | MEMBER'S NAME | | MEMBER'S DATE OF BIRTH |
| Secondary Ins. Co. Phone No. | | Member Identification No. | | | Group Name or No. |
| Address to Submit Claims (if not on card) | | | | | |

### MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT

I hereby authorize Family Eye Care & Surgery to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I request that payment of authorized Medicare benefits be made on my behalf to Family Eye Care & Surgery for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance overage is correct and further authorize Family Eye Care & Surgery to release any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled.

I have read and understand the office policy of Family Eye Care & Surgery.
I authorize Family Eye Care & Surgery to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Signature:_____ Date:_____

Signature
Update:_____ Date:_____