

- ☐ NEW PATIENT
☐ CURRENT PATIENT UPDATE



FAMILY EYE CARE & SURGERY

PLEASE COMPLETE ALL SECTIONS

Patient Name					Phone No. w/Area Code	
First		Middle		Last		
Address						
Street		City		State		Zip Code + 4 (if available)
Sex (please circle)	Date of Birth	Social Security No.	Marital Status (please circle)	Spouse Name		Spouse Date of Birth
F M			M S D Sep			
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)						
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 coverage 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: _____