

# PATIENT INFORMATION

*PLEASE PRINT*

TODAY'S DATE	NAME OF PATIENT (FIRST, MIDDLE, LAST)	BIRTHDATE	AGE
SEX	HOME PHONE	CELL PHONE	WORK PHONE
PATIENT'S ADDRESS (STREET)			
CITY			STATE
			ZIP
SOCIAL SECURITY NUMBER	MARITAL STATUS	OCCUPATION	
EMPLOYER	ADDRESS		
YOUR OPTOMETRIST	ADDRESS		
YOUR MEDICAL DOCTOR	ADDRESS		
PHARMACY	ADDRESS		

## RESPONSIBLE PARTY (if other than patient)

FIRST NAME	MIDDLE	LAST NAME
STREET		CITY
		STATE
		ZIP
PHONE	RELATIONSHIP	

# INSURANCE INFORMATION

<b>P R I M A R Y</b>	POLICYHOLDER'S NAME, FIRST	MIDDLE	LAST NAME
	RELATIONSHIP	BIRTHDATE	
	INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER
	CARRIER'S ADDRESS		

<b>S E C O N D A R Y</b>	POLICYHOLDER'S NAME, FIRST	MIDDLE	LAST NAME
	RELATIONSHIP	INSURANCE CARRIER	BIRTHDATE
		POLICY NUMBER	GROUP NUMBER
	CARRIER'S ADDRESS		

IN CASE OF EMERGENCY, CONTACT (REQUIRED)	RELATIONSHIP
NAME:	
PHONE	

## **AUTHORIZATION AND INSURANCE ASSIGNMENT**

I hereby authorize Capital Eye Consultants, P.C. 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 certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information to my insurance company in order to determine insurance benefits to which I may be entitled. I also authorize the release of my medical information to any physician or facility to which I am referred for diagnostic testing or other services necessary to my treatment. I may revoke this authorization at any time in writing.

## **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I have received a copy of Capital Eye Consultants, P.C.'s Notice of Privacy .

## **FINANCIAL AGREEMENT**

I understand and agree that, regardless of my insurance status, I am responsible for my account. I have read and completed all the information on this sheet and certified it to be true to the best of my knowledge, and I will notify the office of any changes. In the event my account is forwarded to collections due to lack of payment, I will be responsible for any collection and attorney fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_