

PATIENT INFORMATION

Last Name First MI

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

Street Address

PO Box/ Apartment #

City State Zip

Home # Cell #

Work #

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