Patient Information

Please Print

Name____ Date_____/______/_______

Mailing Address: ____

Street Address: ____

Street City State Zip

Date Of Birth___/____/_____ Male/Female (Circle one) Social Security #_________________

Email: ____

Telephone: Home__________________ Cell__________________ Work___________________

Occupation____________________________ Employer________________________________

Address/Phone____

Please Circle One: Single Married Separated Divorced Widowed

Name of Referring Physician (if applicable) ____

Responsible Party:

❑Self Only → Skip to Insurance Information ❑Other Guarantor → Complete This Section

Guarantor's Full Name____________________________________ Date of Birth: __/___/__ ___

Social Security #________________Patient Relationship to Guarantor: ❑Child❑Spouse❑Other

Address (if different) ____

Insurance Information:

Primary Insurance Company Name____

Policy #________________________________ Group #________________________

Secondary Insurance Company Name____

Policy #________________________________ Group #________________________

In case of emergency contact:

Name: ______________________________________ Phone: __________________

Relationship: _________________________________

Insurance Authorization & Assignment:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I authorize my insurance benefits be paid directly to MS Eye as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage. Also, I understand that I am responsible for all legal fees, attorney fees, collection fees, and any other charges involved in collection of my account should it be in default.

_____________________________ _____________________________ ____/____/______

Responsible Party's Signature Patient's Signature Date