

Patient Information

Please Print

Date _____

Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Social Security Number _____ Birth Date _____ Age _____

Employer _____

Address _____ City, State _____ Zip _____

Person Responsible for your Account:

Name _____ Birth Date _____

Address _____ Home Phone _____

Social Security Number _____ Work Phone _____

Relationship to patient _____

Employer _____ Address _____

In case of emergency notify—Name _____ Phone _____

Work Phone _____ Relationship _____

Referred by _____

I Authorize release of medical information to (name) _____

Relationship to patient: Friend Family Other: _____

THIS SECTION MUST BE COMPLETED IN ORDER FOR US TO FILE YOUR INSURANCE.

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE

Name of Insurance Company _____ Phone _____

Address of Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Insurance I.D. Numbers _____ Group # _____

SECONDARY INSURANCE COVERAGE

Name of Insurance Company _____ Phone _____

Address of Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Insurance I.D. Numbers _____ Group # _____

COPY OF INSURANCE CARD(S) ARE NEEDED

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf for any services furnished me by The Center For Sight, LLC, including physician services. I authorize any holder of medical information about me to release to other physicians and or eye care professionals, also to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize the viewing of medication and pharmacy history that may be provided by other companies and providers.

Signature _____ Date _____

***Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill.

Updated by patient or guardian _____ Date _____

Updated by patient or guardian _____ Date _____