

TOTAL EYE CARE PATIENT INFORMATION

PATIENT NAME _____ SPOUSE / PARENT _____
(First Name MI Last Name)

ADDRESS _____ MALE or FEMALE (circle one)

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ BIRTHDATE _____ AGE _____

CELL PHONE (_____) _____ EMAIL ADDRESS: _____

SOCIAL SECURITY NUMBER _____

REFERRED BY _____

PLEASE CIRCLE ONE:		
SINGLE	MARRIED	CHILD
WIDOWED	DIVORCED	

PATIENT / PARENT EMPLOYER _____ WORK PHONE (_____) _____

SPOUSE EMPLOYER _____ WORK PHONE (_____) _____

EMERGENCY CONTACT NAME: _____ PHONE (_____) _____

PRIMARY INSURANCE _____ POLICY NUMBER(S) _____
(Identification #) (Group / Plan #)

SUBSCRIBER NAME _____ SOCIAL SECURITY # _____ BIRTHDATE _____
(Primary Insurance)

SECONDARY INSURANCE _____ POLICY NUMBER(S) _____
(Identification #) (Group / Plan #)

SUBSCRIBER NAME _____ SOCIAL SECURITY # _____ BIRTHDATE _____
(Secondary Insurance)

I hereby authorize TOTAL EYE CARE to furnish information concerning my illness and treatments to INSURANCE CARRIERS and PHYSICIANS directly involved in my care. I authorize payment of any medical benefits to TOTAL EYE CARE. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE: X _____

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to TOTAL EYE CARE for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released to the HEALTH CARE FINANCING ADMINISTRATION and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE: X _____

THANK YOU FOR CHOOSING TOTAL EYE CARE