PATIENT INFORMATION

PERSONAL INFORMATION (Please Print)

Name _____
First Middle Last

Date of Birth _____ Age _____ M/F _____ Social Security # _____

Address _____
Street City State Zip

Phone #: Home (____) _____ Cell (____) _____ Work (____) _____

Occupation _____ Employer _____

Address _____ Phone (____) _____

Marital Status: Single Married Widowed Divorced

Spouse Name _____ Birth Date _____ Phone (____) _____

Address _____ Employer _____

Are you the policy holder on your health insurance? Yes No If not, who is?

1. Policy Holder _____ Birth Date _____ SS# _____
2. Policy Holder _____ Birth Date _____ SS# _____

Complete if under 18 years old or a student

Father's Name _____ Birth Date _____ Employer_____

Address _____ Phone (____) _____

Mother's Name _____ Birth Date _____ Employer _____

Address _____ Phone (____) _____

Are you personally responsible for the payment of your fees? Yes No If not, who is?

Name _____ Relationship _____ SS# _____

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

Who to notify in emergency (nearest relative or friend)

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. **Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In order to control the cost of billing, we request that your co-pays, deductibles, refractions, and non-covered services be paid at the conclusion of each visit.**
3. **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to the office for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, any insurance carrier I may have, or my employer any information needed to determine these benefits or the benefits payable for related services. The office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurance or employer.**
4. **This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.**

SIGNED (Patient, or parent if a minor) _____ **Date** _____