NEW PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

EMAIL : _____

HOME #: (___)_____-_____WORK #: (___)_____-_____CELL #: (___)_____-_____

DATE OF BIRTH: ___/___/_____ SOCIAL SECURITY NUMBER: _____-____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle) SELF SPOUSE CHILD OTHER

SEX: (circle one) FEMALE MALE

WHOM MAY WE THANK FOR REFERRING YOU: _____

WHY ARE WE SEEING YOU TODAY: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ PHONE #: _____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ PHONE #: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

REPSONSIBLE PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: ___/___/_____ SOCIAL SECURITY NUMBER: _____-____-_____

HOME #: (___)_____-_____WORK #: (___)_____-_____CELL #: (___)_____-_____

SEX: (circle one) FEMALE MALE EMPLOYER: _____

INSURANCE INFORMATION

VISION INSURANCE COMPANY: _____

ID #: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $_____ INSURED'S DATE OF BIRTH: ___/___/_____

(OVER)

MAJOR MEDICAL INSURANCE COMPANY: _____

ADDRESS: _____ PHONE #: _____

ID #: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $_____ INSURED'S DATE OF BIRTH: ___/___/_____

ASSIGNMENT AND RELEASE FOR ALL INSURANCES EXCEPT MEDICARE/MEDIGAP

I request that payment of authorized insurance benefits be made on my behalf to Rebman Eyecare, PC for any services furnished me by that provider. I authorize Rebman Eyecare PC to release to the Insurer stated above and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the use of this signature on all my insurance submissions.

_____ _____

Patient's /Guarantor's Signature Date Signed

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rebman Eyecare, PC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

_____ _____

Patient's Signature Date Signed

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and separately agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorney's fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. Otherwise, we will provide an itemized statement you may send to your insurance company for payment. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____

Patient, Parent or Guardian