Deer Penick Eye Clinic, P.A.

Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date of Birth _____ o Male o Female

Address _____ Soc Sec # _____

Street City State Zip

Phone Home (_____)_____ Work (_____)_____ Family Physician _____

Occupation _____ Employer _____

Employer Address _____ Phone (_____)_____

Marital Status: o Single o Married o Widowed o Divorced

Spouse Name _____ Date of Birth _____ Employer _____

Address _____ Phone (_____)_____

Complete if under 18 years or a student

Name of Father _____ Date of Birth _____ Employer _____

Address _____ Social Security # _____ Phone (_____)_____

Name of Mother _____Date of Birth _____ Employer _____

Address _____ Social Security # _____ Phone (_____)_____

RESPONSIBLE PARTY

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

Name _____ Social Security # _____ DOB _____ Relationship _____

Address _____ Phone (_____)_____

Street City State Zip

REFERRED BY o Friend/Relative _____ o Yellow Pages o Newspaper o Other_____

INSURANCE INFORMATION

o Medicare # _____ o Medicaid # _____

o Workers Comp (job injury) to whom is bill to be sent? _____

o Other Medical Insurance _____Group # _____ID# _____

Name/Address 2nd Insurance _____Group # _____ID# _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship_____ Home Phone(_____)_____

Address _____ Work Phone (_____)_____

Street City State Zip

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, any other balance not paid for by your insurance, and any collection agency fees.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
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 minor) _____Date _____

INTERNAL USE ONLY--DO NOT COMPLETE	
CHART NUMBER	**PROVIDER**