SPECIALTY EYE CARE M EDICAL CENTER, INC.

New Patient Information

Last Name:			First Name:	
Address:				
City:			State:	Zip:
Telephone:			Cell Phone:	
Sex:	Male:	Female: □		
Birthday:			Age:	
Social Security Num	n b e r :			
Driver License Num	b e r:			State:
Family Physician:			Phone:	
Referred By:				
EM PLO YM EN T				
Current Occupation	1:			
Work Phone:				
Employer's Name &	k Address:			
M arital Status:	M arried:	Sin gle: Div	orced: Oth	e r: 🔲
Spouse's Name: _				
Spouse's Occupatio	n:			
Spouse's Employer	Name & Address	:		
EM ERGENCY CONT	ACT			
Em ergency Contact	t:		Relationship:	
Address:				
Contact Phone:				
Signature:			Date:	SDECIALTY EVE CADE
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INSURANCE COVERAGE POLICY

As a courtesy to our patients, our office will be glad to bill your insurance company for your medical services. However, we would like you to know that the total amount due is your responsibility. We will be happy to accept payments from your insurance, but any remaining balance on your account is ultimately your responsibility. We ask that you provide us with the proper insurance forms, or below, authorizing your insurance company to remit payments directly to our office. If we do not receive any payments within (90) days of billing, you will be required to take care of your balance yourself. Thank you.

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I, the undersigned, agree to the abbalance due.	bove conditions and understand that I am ultimately responsible for the tota
Signature:	D a t e :
<u>IN S</u>	SURANCE AUTHORIZATION
SPECIALTY EYE CARE MEDICAL CE rendered. I herby authorize the do	e coverage with and assign directly to ENTER, INC. all medical benefits, if any, otherwise payable to me for services octor to release all information necessary to secure the payment of benefits.
Signature:	re on all my insurance submission. Date:
<u>M I</u>	EDICARE AUTHORIZATION
TO SPECIALTY EYE CARE MEDICAL AUTHORIZE ANY HOLD OF MEDICAL ADMINIOSTRATION ITS AGENTS A THAT PAYABLE FOR RELATED SERV AND AUTHORIZES RELEASE OF ME INSURANCE" IS INDICATED IN ITEM	THORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF LCENTER, INC., FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING. NY INFORMATION NEEDED TO DETERMINE THE BENEFITS OR THE BENEFITS VICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE EDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH M9 OF HCFA FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS CLAIMS, ANY SIGNATURE OF THE INFORMATION TO THE INSURER OR
Signature:	Date:

HEALTH HISTORY

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