

DATE _____

YOUR NAME _____
First Middle Last

YOUR SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

YOUR ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____

MARITAL STATUS (circle one) S M W D SEP.

NAME OF SPOUSE, PARENT OR GUARDIAN _____

ABOVE EMPLOYED BY _____ WORK NUMBER _____

NAME OF NEAREST RELATIVE, FRIEND OR NEIGHBOR NOT AT SAME ADDRESS:

NAME ADDRESS PHONE NUMBER

BILL TO NAME ADDRESS PHONE NUMBER

FAMILY PHYSICIAN _____

PLEASE TELL US HOW YOU LEARNED ABOUT OUR OFFICE: Yellow Pages _____ Newspaper _____
Friend/Family _____ Doctor _____ Insurance Brochure _____ Other _____

INSURANCE INFORMATION
IF THE INSURANCE CARD IS IN YOUR SPOUSE, PARENTS'
OR GUARDIANS' NAME, PLEASE ENTER INSURED'S

NAME _____ **SSN#** _____ **DATE OF BIRTH** _____

Eye Physicians, Inc. will be happy to file your insurance, however, all co-payments are due at the time of service, and all charges are the patient's responsibility. We cannot assure coverage from any insurance company. If your insurance requires pre-certification for any procedure, it is your responsibility to obtain it or to inform us. If you have any questions, feel free to ask us.

I agree to pay any costs associated with collecting this debt including, but not limited to, collection agency fees, attorney fees, and/or court costs as applicable.

I understand the above information and accept financial responsibility for all charges incurred.

Signature

I have received a copy of Eye Physicians, Inc. Privacy Act. _____
Signature Date

Patient refused to sign for receipt of Eye Physicians, Inc. Privacy Act

Witness Signature _____ Date _____