PLEASE PRINT

WELCOME TO MEDICAL EYE SPECIALISTS

PATIENT INFORMATION

Patient's Legal Name	Preferred Nickname	Date

Previous Last Name	Date of Birth	Age	Sex M F	Social Security No.

Mailing Address	City	State	Zip

Primary Phone Number	Alternate Phone Number	Email Address

Employer/Occupation	Marital Status Single Married Widowed Divorced	Spouse's Name

RESPONSIBLE PARTY-Complete this section if someone other than the patient is financially responsible

Name	Relationship to Patient

Mailing Address	City	State	Zip

Employer/Occupation	Date of Birth	Social Security No.

Primary Phone Number	Alternate Phone Number	Email Address

INSURANCE INFORMATION-This section must be completed. Please provide your insurance card(s) at visit.

Primary Insurance	Group No.	Policy ID No.	Patient Relationship to Policyholder Self Spouse Child Other

Insurance Address	City	State	Zip

Policyholder Name	Sex M F	Date of Birth

Secondary Insurance/Supplemental	Group No.	Policy ID No.	Patient Relationship to Policyholder Self Spouse Child Other

Insurance Address	City	State	Zip

Policyholder Name	Sex M F	Date of Birth

PLEASE TURN OVER **MUST SIGN BACK SIDE**

INDIVIDUALS WITH WHOM YOU AUTHORIZE US TO SHARE YOUR INFORMATION	
Name	Phone
Address	Relationship to Patient
Name	Phone
Address	Relationship to Patient

EMERGENCY CONTACT (REQUIRED)	
Name	Phone
Address	Relationship to Patient

IMPORTANT INFORMATION-PLEASE READ

I consent to examination, treatment, and procedures which may be performed during office visits, including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for service rendered and agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance. In the event my balance is unpaid after four months from the date of service, my account may be turned over to a collection agency. All costs of collections, including attorneys' fees up to 40% will be added to the balance of my account.

Patient Signature _____ **Date:** _____

Parent Signature _____ **Date:** _____
(If signing for a minor)