PATIENT INFORMATION FORM

Last Name_________________________ First Name________________________ Middle Initial_____

Mailing Address____

City, State, Zip Code____

Social Security # _______________________________ Date of Birth ____________________________

Home #___________________Work#___________________Cell#_______________________________

Email Address____

Employer____

Pharmacy of Choice____

Location____Phone#___________________________

Primary Care Physician—Name____

Address____

Phone____________________________________ Fax____

<u>Please Circle</u>: Single Married Divorced Widowed <u>Please Circle</u>: Student Retired Disabled

INSURANCE INFORMATION

Primary Insurance Company____

Subscriber's Name/D.O.B. ____

ID#___________________________________ Group#_________________________________

Secondary Insurance Company____

Subscriber's Name/D.O.B.____

ID#__________________________________Group#__________________________________

PAYMENTS OF BENEFITS/MEDICAL RELEASE AUTHORIZATION/RESPONSIBLE PARTY SETTLEMENT
I AUTHORIZE PAYMENT OF BENEFITS AS DETERMINED BY MY INSURANCE DIRECTLY TO SOMERS EYE CENTER**. I authorize release of any information necessary to process my insurance claim. As the responsible party, I agree that all charges not directly paid by my insurance are my responsibility.**

X____ DATE_____________________________

Signature