

MEDICAL EYE CARE ASSOCIATES, P.C.

Welcome To Our Office

Today's Date _____

Chart No. _____

PATIENT INFORMATION

Name _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex M F Married _____ Single _____ SS# _____

Home Phone (____) _____ Business Phone (____) _____ Email _____

Employer Name _____ Location _____ Occupation _____

Primary Care Physician _____ Location _____ Phone (____) _____

GUARANTOR INFORMATION

(Complete if patient is under 18 years of age)

Name _____
Last First Middle

Address _____ City _____ State _____ Zip _____
(Complete if different from patient's address)

Home Phone (____) _____ Business Phone (____) _____

Date of Birth _____ Relationship to Patient _____

INSURANCE INFORMATION

HMO _____ Blue Cross Blue Shield _____ Private Insurance _____

Insurance Carrier Name _____ Subscriber ID# _____

Medicare No. _____ Medex No. _____ Medicaid No. _____

Subscriber's Name _____ Relationship to patient _____

Subscriber's Address _____
(Complete if different from patient's address)

Subscriber's Date of Birth _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

City/Town: _____ Zip Code: _____

REFERRAL INFORMATION

How were you referred to our practice?

Newspaper/Magazine Friend/Relative Physician Optometrist Insurance Listing Eye Screening

Name of referral source _____

When was your last eye exam? _____

ASSIGNMENT OF BENEFITS

I authorize my insurance carrier to make payment directly to Medical Eye Care Associates, P.C. for any surgical and/or medical benefits due for services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** I recognize and accept responsibility for any balance remaining after payment of such benefits. A photocopy of this assignment shall be as valid as the original.

RELEASE OF INFORMATION

I also authorize Medical Eye Care Associates, P.C. to release any information acquired in the course of my examination or treatment.

PATIENT OR SUBSCRIBER SIGNATURE _____ DATE _____

HMO REFERRAL WAIVER

I understand that it is my responsibility to obtain a referral from my primary care physician for all medical visits. All charges incurred for medical visits will be my responsibility until a referral is received by Medical Eye Care Associates, P.C.

I also understand that I will be responsible for charges incurred for a routine exam and/or eyewear if I am not eligible for such benefits.

PATIENT OR SUBSCRIBER SIGNATURE _____ DATE _____

MEDICARE WAIVER

I request that payment of authorized Medicare benefits be made to Medical Eye Care Associates, P.C. for any medically necessary service furnished to me by these physicians. I am aware that routine exams without medical diagnoses or complaints **WILL NOT BE COVERED BY MEDICARE**, and that all charges incurred will be my responsibility to pay.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT OR SUBSCRIBER SIGNATURE _____ DATE _____