STUART EYE INSTITUTE
PATIENT INFORMATION

PLEASE PRINT CLEARLY

NAME: ____
Last First M.I.

LOCAL MAILING ADDRESS: ____
Street

____
City State Zip Code

SOCIAL SECURITY #: ____________________

BIRTH DATE: ____________________

LOCAL PHONE: ( ) ____________________

AGE: ____________________

WORK PHONE: ( ) ____________________

MALE / FEMALE (CIRCLE ONE)

OUT OF STATE: ( ) ____________________

SPOUSE'S NAME: ____________________

ALTERNATE PHONE: ( ) ____________________

E-MAIL: ____________________

EMPLOYER NAME: ____________________
ADDRESS: ____________________
____

REFERRED BY: ____________________

PERSON RESPONSIBLE FOR PAYMENT, IF OTHER THAN PATIENT:

NAME: ____
Last First M.I.

ADDRESS: ____
Street

____
City State Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE: ____________________
SUBSCRIBER'S NAME: ____________________
SOCIAL SECURITY: ____________________
DATE OF BIRTH: ____________________
RELATION TO SUBSCRIBER: ____________________
INSURANCE ID # ____________________
GROUP #: ____________________

SECONDARY INSURANCE (If Any): ____________________
SUBSCRIBER'S NAME: ____________________
SOCIAL SECURITY: ____________________
DATE OF BIRTH: ____________________
RELATION TO SUBSCRIBER: ____________________
INSURANCE ID # ____________________
GROUP #: ____________________

LIFETIME INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized medical benefits be made either to me or on my behalf to Stuart Eye Institute for any services furnished me by them.

I authorize any holder of medical information about me to release to the Health Care Financing Administration, Social Security Administration or it's agents any information needed to determine these benefits or the benefits payable to any related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In assigned cases, the physician agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and any non-covered services.

SIGNATURE ____ DATE ____________