Patient Information

☐ Change
☐ New

PATIENT INFORMATION:

Send my monthly statement to:

NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

TELEPHONE NUMBER _____ **SEX** _____

SOCIAL SECURITY NUMBER _____ **BIRTHDAY** _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER TELEPHONE _____

REFERRING PHYSICIAN _____ **ADDRESS** _____

RESPONSIBLE PARTY INFORMATION:

FULL NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

TELEPHONE NUMBER _____

SOCIAL SECURITY NUMBER _____ **BIRTHDAY** _____ **SEX** _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER TELEPHONE _____

OTHER THAN YOUR HOUSEHOLD FOR EMERGENCY

NAME & RELATIONSHIP _____ **PHONE NUMBER** _____

INSURANCE INFORMATION:

Primary Insurance Company:

NAME _____

ADDRESS _____

IDENTIFICATION NUMBER _____

POLICY/GROUP NUMBER _____

WHO HOLDS THIS INSURANCE? _____

PATIENT'S RELATIONSHIP TO INSURANCE HOLDER _____

(Self, Spouse, Child, Other)

Secondary Insurance Company:

NAME _____

ADDRESS _____

IDENTIFICATION NUMBER _____

POLICY/GROUP NUMBER _____

WHO HOLDS THIS INSURANCE? _____

PATIENT'S RELATIONSHIP TO INSURANCE HOLDER _____

(Self, Spouse, Child, Other)

I authorize payment, under the terms of my policy, to Indian Springs Eye Associates upon the submission of an itemized statement for services rendered.

SIGNATURE _____ **DATE** _____

MEDICARE

_____ _____

Name of Beneficiary **HI Claim Number**

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Indian Springs Eye Associates and Dr. Keith S. Hilliard, President for any services furnished me by that physician or supplier. 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 payable for related services."

_____ _____

Beneficiary Signature **Date**