

# PATIENT INFORMATION - PLEASE COMPLETE ALL INFORMATION

Please Print

(THANK YOU!)

LAST NAME FIRST NAME MIDDLE INITIAL  DR.  MISS  MS.  MRS.  
 MR.

ADDRESS CITY STATE ZIP

PHONE HOME CELL WORK SOCIAL SECURITY

DATE OF BIRTH AGE SEX RACE MARITAL STATUS EMAIL ADDRESS

OCCUPATION EMPLOYER NAME

EMPLOYER PHONE EMPLOYER ADDRESS CITY STATE ZIP

SPOUSE/PARENT/GUARDIAN SOCIAL SECURITY OCCUPATION

PERSON TO CONTACT IN CASE OF EMERGENCY

PERSON'S RELATION TO YOU HOME PHONE WORK PHONE ZIP

EMPLOYER PHONE EMPLOYER ADDRESS CITY STATE ZIP

WHO REFERRED YOU TO OUR OFFICE?  EYE DR.  FAMILY DR.  INSURANCE CO.  FRIEND  OTHER

NAME OF REFERRER TELEPHONE #

ADDRESS CITY STATE ZIP

PERSONAL PHYSICIAN TELEPHONE

ADDRESS CITY STATE ZIP

## INSURANCE INFORMATION

PRIMARY SECONDARY

AGREEMENT/I.D. # AGREEMENT/I.D. #

GROUP # GROUP #

SUBSCRIBER NAME SUBSCRIBER NAME

WORKMAN'S COMPENSATION  CARRIER AUTO ACCIDENT   
CLAIM # CLAIM #

LEGAL  ATTORNEY NAME ADDRESS PHONE #

## RELEASE AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE NEVYAS EYE ASSOCIATES TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME. I ALSO AUTHORIZE AND REQUEST MY COMPANY TO PAY DIRECTLY TO NEVYAS EYE ASSOCIATES THE AMOUNTS IN MY PENDING CLAIM FOR ALL SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_