PATIENT INFORMATION - PLEASE COMPLETE ALL INFORMATION

Please Print *(THANK YOU!)*

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

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** _____