

Guardian Eye Associates, PLC

Conrad: \_\_\_\_\_ Dieckhaus: \_\_\_\_\_ Frey: \_\_\_\_\_ Wayburn: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: F M Marital Status: S M W D

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

**SPOUSE/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_ Social Security: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Referred By: \_\_\_\_\_

I AUTHORIZE GUARDIAN EYE ASSOCIATES TO CONTACT ME AT THE FOLLOWING E-MAIL ADDRESS:

\_\_\_\_\_@\_\_\_\_\_

I certify to the best of my knowledge that the above information is complete and correct. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to this office for any service furnished to me by the provider. I authorize the release to Medicare or any other insurance carrier and/or their agents any information necessary to determine benefits payable.

**Signature of Patient/Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I accept full responsibility for payment of my bill including any deductibles, non-covered services or in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary Care Physician prior to being seen in this office. If seen without a referral, I will be responsible for any services rendered.

**Signature of Patient/Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

