

**Patient Name:** \_\_\_\_\_ **Sex M /F SS#** \_\_\_\_\_  
(Last) (First) (Middle)

**Street Address:** \_\_\_\_\_ **Apt. #** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zipcode** \_\_\_\_\_ **Phone Number ( )** \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ May we contact you by e-mail? \_\_\_Y \_\_\_N

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Marital Status: M W S D

Parent/ POA/ Legal Guardian \_\_\_\_\_ **Send bills here? Yes or NO**

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_ - \_\_\_\_\_

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**Who is your family doctor?** \_\_\_\_\_ Did this doctor refer you here today? Yes \_\_\_ No \_\_\_

**Address of family doctor** \_\_\_\_\_

If an Optometrist referred you here today what is their name? \_\_\_\_\_ Address \_\_\_\_\_

**INSURANCE INFORMATION**

(Card copies must be provided to ensure proper claims mailing address)

**PLEASE FILL OUT ALL AREAS IN FULL – THIS IS IMPORTANT FOR ELECTRONIC SUBMISSION**

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance** \_\_\_\_\_

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

**Subscriber Date of Birth** \_\_\_\_\_ **Subscriber Date of Birth** \_\_\_\_\_

Policy ID# \_\_\_\_\_ Policy ID# \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_ Employer: \_\_\_\_\_

**Vision(or Third) Insurance:** \_\_\_\_\_ Policy ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

**I have reviewed the ASSIGNMENT OF INSURANCE BENEFITS on the back.**

**Today's Date:** \_\_\_\_\_

**Signature** of Patient (if over 18) or Legal Guardian \_\_\_\_\_

Subsequent visits: I verify that the information above has not changed in anyway.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

## **ASSIGNMENT OF INSURANCE**

I hereby authorize Ophthalmology Associates, S.C. to release any medical information necessary for the processing of my claims to my insurance carrier and/or my attorney indicated below. I understand this information could include discharge summary, history, and physical. Surgical reports, X-ray and lab results. I authorize direct payment to Ophthalmology Associates, S.C., of any insurance benefit and/or settlement for expenses incurred at his offices which would otherwise be payable to myself, I understand that I am financially responsible for any charges not covered by insurance and/or settlement of my claim. I affirm that I have provided Ophthalmology Associates, S.C., with all and any of my insurance coverage information. I understand that if I withhold any insurance information, which would prevent Ophthalmology Associates, S.C., from billing any of my insurance carriers' properly, those charges would be my responsibility.

**MEDICARE PATIENT:** I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.