doctor & associates
GENERAL, MEDICAL AND SURGICAL EYECARE

PLEASE PRINT

Name: ____
LAST FIRST M.I.

Address: ____
Street Apt # City State Zip

Date of Birth: ________/________/________ Social Security #: ________/________/________

Gender: ________ Male ________ Female Home Phone #: (________)________-________

Phone #: (________)________-_________ work/cell Email: ______________________________

Emergency Contact: ____________________________ Phone #: (________)________-________

Primary Care Physician: ______________________________Referred by: ____________________

Primary Care Physician Address/Phone #____

INSURANCE

Primary:

Insurance Name: ______________________________ ID #: ______________________________

Group #: _______________ Effective Date: _______________ Policyholders Name: _____________________

Policyholders Date of Birth: ________/________/________ Social Security #: ________/________/________

Secondary:

Insurance Name: ______________________________ ID #: ______________________________

Group #: _______________ Effective Date: _______________ Policyholders Name: _____________________

Policyholders Date of Birth: ________/________/________ Social Security #: ________/________/________

All Patients: I am responsible for the refraction fee of **$60.00** if applicable. If I am responsible for a co-payment, it is to be paid at the time of service. If my insurance company requires a referral or preauthorization, it is my responsibility to obtain it prior to the visit and provide it at the time of the visit. If I fail to supply a required referral, it is my responsibility to pay in full for the service(s) rendered at the time of service. If I have a deductible on my insurance policy, I agree that I will be responsible for the bill or any portion that is not covered by my policy due to failure to have met my deductible. I authorize payment of medical benefits to Leslie C. Doctor, M.D. for services described. I accept full responsibility for total amount of the bill.

Signed: ____ Date: ______________________

Medicare Patients: Medicare does not cover the refraction fee of **$60.00**. This payment is due at the time of service. If Medicare denies payment, I agree to be fully responsible for payment of services rendered. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers, or the billing agent of this physician, any information needed for this is a related Medicare claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signed: ____ Date: ______________________