



CENTRE EYE PHYSICIANS & SURGEONS

PERSONAL INFORMATION (Please Print):

Name (First / M.I. / Last): _____
 Date of Birth: ____/____/____ Age: ____ Social Security #: ____ - ____ - ____ Sex at Birth: ____
 Address (Street/City/State/Zip): _____
 Phone (Home): _____ (Cell): _____ Preferred Contact Number: Home Cell
 Relationship Status: Single Married Widowed Divorced Domestic Partner
 Occupation: _____ Employer: _____
 Primary Care Physician: _____ Referring Physician: _____

HIPAA/EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____
 Home Phone: (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone: (____) ____ - ____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID#: _____ Group #: _____
 Subscriber Name: _____ DOB: ____/____/____ SS#: _____
 Employer: _____ Employer Address: _____

Secondary Insurance Company: _____ ID#: _____ Group #: _____
 Subscriber Name: _____ DOB: ____/____/____ SS#: _____
 Employer: _____ Employer Address: _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE OR STUDENT:

Parent #1: Mother Father
 Name: _____
 Date of Birth: ____/____/____ Phone: _____
 Address: _____

Parent #2: Mother Father
 Name: _____
 Date of Birth: ____/____/____ Phone: _____
 Address: _____

WORKERS COMPENSATION:

Company Name&Address: _____
 Contact Person: _____ Phone: _____
 Claim # (If available): _____

FINANCIAL ASSIGNMENT AND AGREEMENT (Please initial each line):

_____ Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any co-pays, deductible, co-insurance amounts, or any other balance not paid by your insurance. In order to control the cost of billings, we request that all amounts not paid by insurance be paid at the conclusion of each visit. If collection efforts must be made, the cost of collection fees is assumed by the guarantor.

_____ I request the payment of Medicare/Insurance benefits be made on my behalf for any services provided to me. I authorize the holder of medical information about me to release to the health care financing administration, its agents, or any insurance carrier I may have, any information needed to determine the benefits payable for related services.

_____ This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ I acknowledge that the Centre Eye Physicians and Surgeons Notice of Privacy Practice is available to view at www.centreeye.com. I understand that a paper copy of the Notice of Privacy Practices can also be requested at the time of my visit. I understand that Centre Eye Physicians and Surgeons may disclose information about me and the treatment I am receiving for purposes of continuous treatment, payment, and health care operations.

Patient or Guardian Signature: _____ Date: ____/____/____