

ANNE ARUNDEL EYE CENTER

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zipcode _____ Marital Status: S M D W

DOB ____/____/____ Sex: M / F S.S. ____/____/____ Referred By _____

Home Phone (____) _____ Work Ph (____) _____ Cell Ph (____) _____

Primary Care Physician _____ Location of PCP _____

Emergency Contact _____ Relation _____ Emer. Phone _____

EMAIL _____

Primary Insurance

Ins Company _____

Policy Holder _____

Relationship _____ D.O.B. _____

Policy/Member Number _____

Group # _____

Co-Pay _____ Employer _____

Secondary Insurance

Ins Company _____

Policy Holder _____

Relationship _____ D.O.B. _____

Policy/Member Number _____

Group # _____

Co-Pay _____ Employer _____

Workman's Compensation Claims

Guarantor _____

Date of Injury _____

Address _____ City _____ ST _____ Zip _____

Patient's Authorization

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, co pays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the provider or designated representative to contact me by telephone or mail about appointments, billing, and medical care. I authorize the physician to release any medical information required to process this claim. I acknowledge that I have been offered a copy of the "Notice of Privacy Practices". I authorize the disclosure of my protected health information to _____. A fee for no-shows may apply.

* _____

Signature of Subscriber or Beneficiary

Date