

# EYE EXCELLENCE

*Thank you for choosing our practice for your eyecare needs. To better serve you, please complete the following.*

Mr. Mrs. Miss Ms Dr: \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_

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

Home phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_ e-mail \_\_\_\_\_

Employer \_\_\_\_\_ WK # \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: S M D W Spouse/Partner Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse/Partner Social Security # \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

Spouse/Partner Employer \_\_\_\_\_ WK # \_\_\_\_\_

Referred by \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY

Person responsible for payment \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (other than spouse) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ WK Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Vision Plan Name \_\_\_\_\_ Name of Insured \_\_\_\_\_

*If your visit today is related to a worker's compensation injury, please provide to following information:*

Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_ Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

ASSIGNMENT OF BENEFITS  
AND  
RELEASE OF MEDICAL INFORMATION

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Eye Excellence. I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize the listed insurance company(s) to remit directly to Eye Excellence all payments of benefits otherwise payable to me under the provisions of my policy(s).

I understand that I am financially responsible to Eye Excellence for charges not covered by my insurance(s) including co-payments, deductibles, and non-covered services or supplies. I further understand I am financially responsible for failing to obtain necessary referrals as directed by my managed healthcare plan or by failing to provide accurate insurance information at the time of my visit.

In order to keep our fees competitive, payment is requested at the time of service.

Signature\_\_\_\_\_Date\_\_\_\_\_