The Eye & Laser Center

PATIENT INFORMATION

PLEASE PRINT INFORMATION				
PATIENT'S NAME		S.S. #	DATE OF BIRTH	☐ MALE ☐ FEMALE
MAILING ADDRESS		CITY & STATE	ZIP CODE	
HOME PHONE	CELL PHONE	EMAIL ADDRESS	MARITAL STATUS *(circle one)* S M W D	
EMPLOYER		WORK PHONE	WORK FAX #	
EMPLOYER'S ADDRESS		CITY & STATE	ZIP CODE	
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE NUMBER(S)		
FAMILY PHYSICIAN NAME, ADDRESS, PHONE NUMBER				

COMPLETE IF APPLICABLE *(Circle whether for Spouse or Parent)*		
SPOUSE OR PARENT NAME	S.S. #	DATE OF BIRTH
SPOUSE'S OR PARENT'S EMPLOYER	WORK PHONE	WORK FAX #
EMPLOYER'S ADDRESS	CITY & STATE	ZIP CODE

RESPONSIBLE PARTY INFORMATION			
RELATION TO PATIENT			
PERSON RESPONSIBLE FOR PAYMENT		S.S. #	DATE OF BIRTH
RESPONSIBLE PARTY'S MAILING ADDRESS		CITY & STATE	ZIP CODE
HOME PHONE	CELL PHONE	BUSINESS PHONE	EMPLOYER

REFERRAL INFORMATION *(Please indicate how you heard of our office)*

☐ Doctor (name) ______________________________

☐ Friend / Relative (name) ______________________________

☐ Newspaper (which one) ______________________________

☐ Billboard (which one) ______________________________

☐ Other (please specify) ______________________________

PLEASE COMPLETE BOTH SIDES

INSURANCE INFORMATION		
PRIMARY INSURANCE		POLICY #
ADDRESS TO SEND CLAIMS		PHONE #
NAME OF INSURED	RELATION TO PATIENT	INSURED DATE OF BIRTH

SECONDARY INSURANCE		POLICY #
ADDRESS TO SEND CLAIMS		PHONE #
NAME OF INSURED	RELATION TO PATIENT	INSURED DATE OF BIRTH

PATIENT AUTHORIZATION

Before we can file your insurance claim, we need to obtain a Release of Information and Payment Authorization from you. By signing the following statement, you are agreeing to let us release any medical information necessary for your insurance company to determine the benefits payable for the services we provide. You are also requesting that your insurance company send payment of those benefits to Lancaster Eye Clinic, P.A. (doing business as The Eye & Laser Center).

I DO HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS AND REQUEST PAYMENT OF BENEFITS TO THE PHYSICIAN WHO ACCEPTS ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLES, COINSURANCE AMOUNTS, CO-PAYMENTS, AND NONCOVERED SERVICES.

Signature ***(Patient or Authorized Representative)*** **Date**

Signature by Mark

Witness