



Date: _____
MR# _____
Info entered by: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last Name First Name M.I.

SEX: _____ MARITAL STATUS: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ AGE: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

MOBILE NUMBER: _____ EMAIL ADDRESS: _____

ADDRESS: _____ APT# _____

CITY: _____ STATE: _____ ZIP: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

Name: _____ Address: _____

Phone: _____

HOW WERE YOU REFERRED TO OUR PRACTICE? Please circle one of the following.

NEWSDAY T.V. RADIO FRIEND / RELATIVE VAL PAK YANKEE TRADER

INTERNET / WEBSITE: _____ DOCTOR: _____

OTHER: _____

IS THIS RELATED TO WORKERS COMPENSATION OR NO FAULT? _____

PRIMARY INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE ID #: _____ GROUP #: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY # _____

RELATIONSHIP TO INSURED: SELF SPOUSE MOTHER FATHER OTHER: _____

DO YOU HAVE A SEPARATE HOSPITAL CARRIER? _____ IF YES, NAME OF CARRIER: _____

SECONDARY INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE ID #: _____ GROUP #: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: _____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY # _____



RELATIONSHIP TO INSURED: SELF SPOUSE MOTHER FATHER OTHER: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

EMPLOYERS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ EMPLOYERS PHONE #: _____

NAME OF SPOUSE: _____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S WORK #: _____

DO YOU AUTHORIZE RELEASE OF PERSONAL INFORMATION? YES NO MEDICAL BILLING
(IF YES, PLEASE CHECK BOXES)

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME: _____ TELEPHONE: _____

RELATIONSHIP TO PATIENT: _____

BILLING INFORMATION

NON INSURED PATIENTS:

If you are not insured, it is our office policy here at Long Island Eye Surgical Care, PC that payment is due at the time services are rendered.

I understand that I am financially responsible for payment of all charges incurred or services received from this doctor's office.

Signature of Patient/ Guardian if Minor

Date

INSURED PATIENTS:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

Name of Insurance Company (ies)

I assign directly to Long Island Eye Surgical Care, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred for services received from this doctor's office whether or not paid by insurance. I hereby authorized Long Island Eye Surgical Care, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/ Guardian if Minor

Date