PATIENT FINANCIAL INFORMATION SHEET

DATE_____ REFERRED BY_____

PATIENT'S FULL NAME_____HM PH: (_____)_____

ADDRESS_____
street city state zip

EMAIL ADDRESS: _____ CELL # _____

SEX_____BIRTHDATE_____AGE_____SS#_____
MM/DD/YYYY

PATIENT'S EMPLOYER _____WK PH:_____

PERSON RESPONSIBLE FOR BILL

NAME_____ HM PH: (_____)_____

ADDRESS_____
street city state zip

EMPLOYER_____WK PH: _____

SOCIAL SECURITY NUMBER: _____ RELATIONSHIP TO PATIENT_____

PRIMARY MEDICAL INSURANCE COVERAGE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

SECONDARY MEDICAL INSURANCE COVERAGE:_____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

DO YOU HAVE A SEPARATE VISION POLICY THAT COVERS YOUR ROUTINE EYE CARE? Y or N

VISION INSURANCE COVERAGE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING. THIS INFORMATION IS REQUIRED FOR BILLING AND DEBT COLLECTION PURPOSES.

FATHER'S NAME_____FATHER'S DATE OF BIRTH: _____

FATHER'S SOCIAL SECURITY NUMBER: _____

MOTHER'S NAME_____MOTHER'S DATE OF BIRTH: _____

MOTHER'S SOCIAL SECURITY NUMBER:_____

By signing below, I agree that:

1) I have received or reviewed a copy of the Notice of Privacy Practices for The Raleigh Eye Center, P.A.

2) I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail, or FAX. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

X_____ DATE _____
Patient or Legal Guardian

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS INCLUDING PRESCRIBED AND OVER THE COUNTER.
YOU MAY ATTACH A SEPARATE SHEET IF NECESSARY.

MEDICATION	REASON TAKEN	DIRECTIONS

PHARMACY: _____

ADDRESS _____

PHONE NUMBER: _____FAX NUMBER: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE LIST AND TELL US YOUR REACTION TO TAKING THIS MEDICINE.

_____

_____

LIST ANY SURGERIES YOU HAVE HAD:

SURGERY	DATE

LIST ANY MAJOR ILLNESSES OR INJURIES:

ILLNESS OR MAJOR INJURY	DATE