EMERALD COAST EYE INSTITUTE, P.A.

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(850) 689-3067

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PATIENT INFORMATION

Name ______________________________ ❏ M ❏ F
Last Name First Name Middle

Address ______________________________

City ______________ State ______________ Zip ______________

Home Ph. __________ Cell Ph. __________ Birthdate __________ Soc Sec # __________

Work Ph. __________ Employer __________ Occupation __________

Marital Status __________ Spouse __________ Spouse D.O.B. __________

Emergency Contact Person: Name ______________________________ Phone __________

Email Address ______________________________

RESPONSIBLE PARTY INFORMATION

Relationship to patient (circle one) SELF MOTHER FATHER SPOUSE OTHER

Name ______________________________
Last Name First Name Middle

Address ______________________________

City ______________ State ______________ Zip ______________

Home Ph. ______________ Email Address ______________

Employer ______________ Bus. Ph. ______________

Birthdate ______________ Social Security # ______________

INSURANCE INFORMATION

(Please give your insurance cards to the receptionist — a copy will be made and filed in your medical record)

Primary Insurance Company ______________________________

Insurance __________ Policyholder Name __________ Policyholder D.O.B. __________

Secondary Insurance Company ______________________________

Insurance __________ Policyholder Name __________ Policyholder D.O.B. __________

Primary Medical Dr. ______________________________

Primary Eye Care Dr. ______________________________

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Whom may we thank for referring you? ______________________________ Date __________

Rev. 1-09

LIFETIME AUTHORIZATION

Medicare and/or Insurance Certificate For Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or other insurance carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I also request that this apply to any other insurance I may have.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

The undersigned understands that he/she is financially responsible to Emerald Coast Eye Institute, P.A. for charges involving the patient not covered by insurance and agrees to timely pay the same.

The undersigned agrees that should his/her account be in arrears 60 or more days, the entire account balance shall be immediately due and payable. Should Emerald Coast Eye Institute, P.A. be unable to obtain payment for the balance due, we will pursue all available legal remedies and the undersigned agrees to timely pay to Emerald Coast Eye Institute, P.A. all collection fees and court costs incurred in doing so.

Any parent or legal Guardian (regardless of marital status) who brings in a minor for treatment is, and hereby agrees to be, responsible for paying the minor's account in full.

Several missed appointments, habitual noncompliance or abusive behavior constitutes grounds for dismissal from our practice.

Signed ______________________________ Date ____________________
(Patient)

By ______________________________

Title or Relationship to Patient ______________________________

(If signed by other than beneficiary, state title or relationship and the reason the patient was unable to sign.)