REEVE-WOODS EYE CENTER PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ (Last / First / Middle) DOB: _____ SEX: _____

MAILING ADDRESS: _____ (Street / City / State / Zip) PHONE: _____ (Home Phone)

OCCUPATION: _____ EMPLOYER: _____ PHONE: _____ (Business Phone)

SOCIAL SECURITY NO.: _____ SPOUSE: _____ SPOUSE SSN:: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

IF YOU ARE A NEW PATIENT PLEASE ANSWER THE FOLLOWING:

HOW DID YOU HEAR ABOUT US? _____

PREVIOUS OPTOMETRIST: _____ DATE OF LAST EYEGLASS PRESCRIPTION: _____

LIST PREVIOUS OPHTHALMOLOGIST (EYE SURGEON) & DATE SEEN: _____

MEDICARE BILLING AUTH: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to REEVE-WOODS EYE CENTER for any services furnished me by them. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services (e.g. refraction's). Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____

PRIVATE BILLING AUTH: _____

Authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to be made to the REEVE-WOODS EYE CENTER for any services furnished me by them. I authorize any holder of medical information about me to be released

to the above named insurance company and any information needed to determine these benefits or the benefits payable for related services.

Signed _____ Date _____