

PERSONAL INFORMATION

Social Security No.	Phone Number	Account Number
Last Name	First Name	Middle Initial
Present Street Address	City	State Zip
Permanent Residence - Street Address (If Different)	City	State Zip
Date of Birth	Sex	
Month Day Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	
(If Married) Spouse's Name	Marital Status	
	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Family Physician/Phone Number/Address	If Minor, Who's Responsible/Relation/Address	
Referring Physician	Complete Name/Town/Phone Number (All if Possible)	

EMPLOYMENT INFORMATION

Name	Patient	Father	Name	Spouse	Mother
Place of Employment/Phone Number			Place of Employment/Phone Number		
Address			Address		
City State Zip			City State Zip		
Drug Allergies/Notes:					

Name of Insured _____ Medicaid # _____

Date _____ Health Insurance Number _____

I request the payment of authorized medicare benefits be made to **Valley Eye Center, P.A.** on my behalf for any services furnished me by or in **Valley Eye Center, P.A.** including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I UNDERSTAND THAT ANY REIMBURSEMENT FROM MEDICARE AND/OR PRIVATE INSURANCE LESS THAN \$25.00 THAT RESULTS IN OVERPAYMENT WILL BE KEPT ON MY ACCOUNT FOR CREDIT FOR FUTURE VISITS.

I WILL BE PAYING BY: _____ CASH _____ CHECK _____ VISA/MASTERCARD/AM EXP

TYPE OF INSURANCE ON BACK OF FORM

