Comprehensive Eye Associates

PATIENT NAME _____ BIRTHDATE _____Title:
LAST FIRST M.I.

Mr. ☐
Mrs. ☐
Ms. ☐
Miss. ☐
Dr. ☐
Rev. ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL ADDRESS_____

PREFERRED CONTACT: HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ SEX: MALE ☐ FEMALE ☐

PLACE OF EMPLOYMENT _____ OCCUPATION _____

STATUS: FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ DISABLED ☐ STUDENT ☐ RETIRED ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

ETHNICITY: HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐

Race:
Native American ☐
Alaska Native ☐
Asian ☐
African American ☐
Pacific Islander ☐
White ☐

PREFERERRED LANGUAGE_____

SOCIAL SECURITY NUMBER_____

REFERRED BY_____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE

NAME _____ RELATIONSHIP TO PATIENT

ADDRESS _____ CITY _____ STATE_____

PHONE _____ SOCIAL SECURITY NUMBER _____ DOB _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S NAME_____

INSURED'S EMPLOYER _____ INSURED'S BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE AND/OR MEDICARE PAYMENT IS CORRECT. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT OF MY INSURANCE AND/OR MEDICARE BENEFITS, AND I AUTHORIZE PAYMENT OF THESE BENEFITS DIRECTLY TO COMPREHENSIVE EYE ASSOCIATES ON MY BEHALF FOR ANY SERVICES AND MATERIALS FURNISHED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. IF I HAVE OTHER HEALTH INSURANCE COVERAGE (AS INDICATED ON ITEM 9 OF THE HCFA-1500 CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM), MY SIGNATURE AUTHORIZES RELEASE OF THE ABOVE MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN, AND AUTHORIZES MY DOCTOR TO ACT AS MY AGENT, AS ABOVE. FURTHER, IT IS THE PATIENT'S UNDERSTANDING THAT HE/SHE IS RESPONSIBLE FOR ALL FEES OF COMPREHENSIVE EYE ASSOCIATES NOT COVERED BY MEDICAL INSURANCE AND IN THE EVENT THAT A STATEMENT FOR FEES IS NOT PAID WITHIN THIRTY (30) DAYS OF THE DATE DUE, THE PATIENT SHALL BE FURTHER OBLIGATED TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT THE RATE OF 18% PER ANNUM. REVISED FEBRUARY 19, 2003.

SIGNATURE _____ **DATE**

PARENT/GUARDIAN ☐ POA ☐ CAREGIVER ☐ PATIENT NOT MENTALLY/PHYSICALLY CAPABLE OF SIGNING ☐