

PATIENT INFORMATION

Patient's Name		Date of Birth	
Address	City	State	Zip
Home Phone Number ()	Work phone number ()		EXT
Optional Contact Information:			
Cell Phone Number ()		E-mail Address	
Patient's Social Security #	Sex (circle one) M F	Marital Status	
Person responsible for bill of minor			
Patient's employer		Occupation	
Nearest relative to patient		Phone Number ()	
How did you hear about our practice?			
<input type="checkbox"/> Doctor	<input type="checkbox"/> Friend	<input type="checkbox"/> Other	
Name of your family physician		City/Town	

PRIMARY INSURANCE OR MEDICARE

Insurance Company	Relationship to Patient
Member's Name	Member's Date of Birth M or F
Member ID	Policy/Group Number
Employer's Name	Phone Number

SECONDARY INSURANCE

Insurance Company	Relationship to Patient
Member's Name	Member's Date of Birth M or F
Member ID	Policy/Group Number
Employer's Name	Phone Number

VISION SERVICE PLAN

Member Name	Relationship to Patient
Member ID	Member's Date of Birth
Member Employer	

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Fox Valley Ophthalmology all **medical** benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I here by authorize the doctor to release all information necessary to secure the payment for benefits. I authorize the use of the signature on all my insurance submissions.

Signature of Patient	Date
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