

PATIENT INFORMATION

Patient's Name: _____
 First Middle Last Email Address

Address : _____
 P.O. Box Street Address

City State Zip

Telephone: _____
 Home Work Cell

Date of Birth: _____ SS# _____ Marital Status: S M W Sex M F

Race: _____ Language: _____

Employer _____ Occupation _____

Address City State Zip

Spouse/Responsible Party's Name: _____
 First Last

P.O. Box Street Address City State Zip

Date of Birth: _____ Relationship: _____ SS# _____

Primary Insurance Information

Name of Primary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

ID Number: _____ Group Number: _____

Secondary Insurance Information

Name of Secondary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

ID Number: _____ Group Number: _____

Tertiary/Vision Insurance Information

Name of Tertiary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

ID Number: _____ Group Number: _____

Referring Physician: _____ Family Physician: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other insurance company benefits be made either to me or on my behalf to Berks Eye Physician & Surgeons for any services furnished me by Berks Eye Physicians and Surgeons. Regulations pertaining to Medicare assignment of benefits apply. I authorize Berks Eye Physician & Surgeons to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claims / other insurance company claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Berks Eye Physicians and Surgeons. I understand it is mandatory to notify Berks Eye Physicians and Surgeons of any other party who may be responsible for paying for my treatment.

Signature: _____ Date: _____