Berks Eye
Physicians & Surgeons, Ltd.

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: _____

Family Doctor: _____ Referring Doctor: _____

Insured/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: _____

Secondary Insurance Information

Name of Secondary Insurance: _____

Tertiary/Vision Insurance Information

Name of Tertiary Insurance: _____

If you are being seen for a work related injury please list your Employer below:

Employer _____ Occupation _____

_____
Address City State Zip

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: _____