

**PLEASE FILL OUT ENTIRE FORM
(PLEASE PRINT CLEARLY)**



Date: _____

Name: Mr/Miss/Mrs _____

Your Spouse or Parent: _____

Guarantor (Responsible Party): _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Summer Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # : _____

Telephone: Home: _____ Business: _____

Referred by: _____ Employed by: _____



Medicare/ Medicaid:

Medicare Number: _____

Is Medicare your primary insurance? yes no

Medicaid Number: _____



Other Insurance: THIS INFORMATION MUST BE PROVIDED FOR INSURANCE BILLING

Name of Insurance Company: _____

Billing address: _____

Policyholder information:

Policyholder: _____ Relationship to patient: _____

Employer/Company: _____ Active _____ Retired _____

Policy No: _____ Group No: _____

Policyholder Date of Birth: _____ Policyholder SS #: _____

LIFETIME AUTHORIZATION

I request that payment of authorized health insurance benefits be made either to me on my behalf or to the Montgomery Eye Center for any services furnished me by any doctor who is associated with the Montgomery Eye Center.

I authorize any holder of medical or other information about me to release to my health care plan, HCFA, or any of their agents any information needed to determine these benefits for related services.

I acknowledge that a copy of Notice of Privacy Practices describing how health information will be used or disclosed is available to me upon request.

Signature of Patient: _____

If filled out by person other than patient, please give your name and relationship: _____

IF YOU HAVE INSURANCE CARDS, WE WOULD LIKE TO MAKE A COPY OF THEM.

THANK YOU