PLEASE FILL OUT ENTIRE FORM
(PLEASE PRINT CLEARLY)

MONTGOMERY EYE CENTER
Serving Naples Since 1970

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: ____________________ Cell # ____________________

Email Address: _________________________________

Referred by: ______________________________ Employed by: ___________________________________

Emergency Contact Person: _________________________________ Phone # _________________________

Medicare/ Medicaid:

Medicare Number: _____________________________

Is Medicare your primary insurance? ☐ yes ☐ no

Medicaid Number: _____________________________

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Other Insurance: **THIS INFORMATION MUST BE PROVIDED FOR INSURANCE BILLING**

Name of Insurance Company: _______________________________

Billing address: _______________________________

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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