New Patient Information Form

Name: _____

Salutation: Mr / Mrs / Ms / Dr Nickname: _____

Date of Birth: _____ / _____ / _____ Email: _____

Spouse, Parent, Legal Guardian: _____

Guarantor (Responsible Party): _____

Main Address: _____ City: _____ State: _____ Zip: _____

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

Social Security Number: _____

Home Phone: _____ Business: _____ Cell: _____

Referred by: _____ Employed By: _____

Emergency Contact: _____ Emergency Phone: _____

IF YOU HAVE YOUR INSURANCE CARDS, WE WILL SCAN THEM AND RETURN THEM TO YOU AT THE END OF YOUR VISIT

Medicare / Medicaid Information

Medicare Number: _____ Is Medicare your primary insurance? ☐ Yes ☐ No

Medicaid Number: _____

Other Insurance Information

Name of Insurance Company: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Policyholder: _____ Relationship to Patient: _____

Employer/Company: _____ Active / Retired

Policy Number: _____ Policyholder DOB: _____ / _____ / _____

Group Number: _____ Policyholder SSN: _____

LIFETIME AUTHORIZATION / ASSIGNMENT OF BENEFITS

By my signature below, I hereby assign all medical/surgical benefits to Montgomery Eye Center for services at Montgomery Eye Center and request that payment of authorized benefits be made to the assignee on my behalf. I authorize release of any medical information as may be required by Medicare and/or my other health insurance company to determine my health benefits and issue payment to assignee for related medical claims.

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 or Responsible Party: _____ **Date:** _____

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