

NEW PATIENT INFORMATION

DATE _____

NAME _____ E-MAIL ADDRESS _____

ADDRESS _____
LAST FIRST MIDDLE INITIAL

HOME# _____ CELL # _____ WORK # _____
STREET CITY STATE ZIP

SOCIAL SECURITY # _____ AGE _____ BIRTHDATE _____ MALE FEMALE

OCCUPATION _____ EMPLOYER _____

PRIMARY INSURANCE _____ POLICY # _____

SECONDARY INSURANCE _____ POLICY # _____

VISION INSURANCE _____ POLICY # _____

MARITAL STATUS _____ SPOUSE'S NAME _____

SPOUSE'S BIRTHDATE _____ SPOUSE'S EMPLOYER _____

SPOUSE'S SOCIAL SECURITY # _____ SPOUSE'S WORK # _____

PARENT OR GUARDIAN NAME _____ S.S.# _____ BIRTHDATE _____

EMERGENCY CONTACT _____ PHONE # _____

FAMILY PHYSICIAN _____ PHONE # _____

IF YOUR INSURANCE COVERAGE IS THROUGH A SPOUSE OR OTHER FAMILY MEMBER YOU MUST FILL OUT THIS SECTION COMPLETELY

INSURED'S NAME _____ RELATIONSHIP _____

S.S.# _____ DOB _____ HM # _____ WK # _____

EMPLOYER NAME _____

INSURANCE POLICY _____ POLICY # _____

CO-PAYMENTS AND DEDUCTIBLES FOR INSURANCE MUST BE PAID AT TIME OF SERVICE

I hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare and other governmental sponsored programs, private insurance, and any other health plans to which I am entitled to **MEDICAL VISION TECHNOLOGY OPHTHAMOLOGY GROUP, INC.** This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits, including Medicare under Title XVIII of the Social Security Act.

I understand that I am financially responsible for all charges whether or not paid by insurance, including any deductible amount, co-insurance or non-covered services.

SIGNATURE OF PATIENT OR GUARDIAN