PATIENT INFORMATION

Date _____/_____/_____
Patient's Name_____ _____
First Name Middle Initial Last Name Suffix Nick name
Mailing Address _____City_____ State_____ Zip _____
Date of Birth ____/____/____ Age_____ Gender: M F Patient's SSN _____
Parent's Name if minor_____ Race: _____ Ethnicity: Hispanic or Non-Hispanic
Circle one
Home (____) _____ Work (____) _____ Ext _____
Cell (____) _____ Email _____
ð Married ð Widowed ð Single ð Divorced ð Minor

Occupation_____ Patient's Employer/School_____
Employer/School address _____ Employer/School Phone (___) _____
Spouse's Name_____ Birthdate _____ SS# _____
Spouse's Employer_____ Spouse's Work Phone (____) _____
How did you hear about us? _____

INSURANCE INFORMATION

Name of the Primary Insurance _____
Name of the person who the insurance under? _____ Relationship to patient_____
DOB of insurer ____/____/____ID # _____ Group #_____
Name of the Secondary Insurance _____
Name of the person who the insurance under? _____ Relationship to patient_____
DOB of insurer ____/____/____ID # _____ Group #_____

I certify that the above information is true and correct to the best of my knowledge. I request that payment of the authorized benefits be made directly to Hatfield Family Eye Care, PLLC for any services and/or materials furnished and authorize the claim to be filed by Hatfield Family Eye Care, PLLC to the above insurer on my behalf. I further agree to pay any charges not paid or covered by the above mentioned insurance company to Hatfield Family Eye Care, PLLC.

I authorize the release of any information needed to provide medical treatment and service or to obtain authorizations or payments from the insurance company or other payer.

Medicare and insurance companies sometimes have a deductible that must be met before they will pay. The patient is responsible for paying the covered charges until the deductible is met.

I have read and understand the information above and agree to pay for any services and materials I order but which are not covered by my insurance.

_____ _____/_____/_____
Patient's Signature **Date**

_____ _____
Parent or Legal Guardian's Signature if the Patient is a minor child. **Relationship to patient**