Reason for Visit: _____

Eye Disease Consultants, LLC

Name_____ Date of Birth_____ Sex_____
Last First Middle Initial

Address_____ City_____ State_____ Zip_____

Phone ( )_____ Bus.Phone ( )_____ Cell( )_____

Employer_____ Occupation_____ SS#_____

Address_____ City_____ State_____ Zip_____

Race_____ **Ethnicity (Country of Origin)**_____ **Preferred Language**_____

EMAIL:_____

Insurance Information

Primary Insurance Co._____ Policy Holder_____ DOB_____

Member ID_____ SS#_____ Group#_____

Secondary Insurance Co._____ Policy Holder_____ DOB_____

Member ID_____ SS#_____ Group_____

Emergency Contact Information

Name_____ Relationship_____

Address_____ Phone_____

Referral Information

Primary Care Physician_____ Phone_____

Name of Referring Party_____ Phone_____

Address_____ City_____ State_____ Zip_____

Name of Preferred Pharmacy_____ Phone_____

Address_____

Financially Responsible Party

Guarantor Name:_____ Relationship_____ DOB_____

Address_____ City_____ State_____ Zip_____

Phone( )_____ Bus Phone( )_____ Cell ( )_____

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to Eye Disease Consultants of any medical benefits otherwise payable to me. I understand am financially responsible to Eye Disease Consultants for charges not covered by this assignment. I authorize Eye Disease Consultants to release any information requested to support my claim including any information which constitutes a psychiatric communication and/or relates to treatment of alcohol and drug abuse. If any disclosed information contains AIDS/HIV information, state law prohibits further disclosure without specific written consent.

FINANCIAL RESPONSIBILITY:

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default.

SELF-REFERRAL ACKNOWLEDGMENT

I understand that if at any time my insurance plan requires a referral or prior approval and I receive care without it, my insurance plan may not cover my services and I agree to pay all charges.

_____ Date_____
Signature

_____ Date_____
Responsible Party/Parent Signature