Garden City EyeCare

PATIENT INFORMATION FORM

Date: _____ *Referred By: _____

*Name: _____ Title: __Miss __Mrs __Mr __Ms _____ (Other)
(check one)

*Address: _____ City: _____ State: ___ Zip: _____

*Home Phone: _____ *Cell Phone: _____

E-mail: _____ SSN: _____

*Date of Birth: _____ Age: _____ Sex: ___M ___F

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

In Case of Emergency Please Notify: _____ Phone: _____

*Person responsible for billing (if different from above): _____

Address (if different from above):_____ Phone: _____

INSURANCE INFORMATION

Primary: _____ #:_____

Secondary: _____ #:_____

*Insured's SSN (if different from patient):_____ *Insured's DOB: _____

Authorization Number (if required): _____

Worker's Comp: Work Related? ___Y ___N Date of Injury: _____

I HEREBY AUTHORIZE GARDEN CITY EYECARE, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT, AND I HEREBY ASSIGN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEFENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

***Patient Signature: _____ *Date: _____**

*** Required Field**