Garden City EyeCare, Inc.

PATIENT INFORMATION

Date:____________________ Referred By: ____________________________________

Name:______________________________ Title:__miss __mrs __mr __ms __other

Address: ____

City:_____________________ State: _____________ Zip Code:____________________

Telephone:___________________________ Social Security # ____________________

Cell: ________________________________ Email:_______________________________

Date of Birth:________________ Age:_____ Sex: __M __F

Employer:________________________ Occupation: ____________________________

Address:_______________________________________ Telephone: ______________

In Case of Emergency Please Notify:___________________ Telephone: _____________

Person responsible for billing (if different from above)

Name: ____

Address:_______________________________________ Telephone: _____________

INSURANCE INFORMATION

Primary:_________________________#: _____________________________________

Secondary:_______________________#: _____________________________________

Insured's SSN:____________________ Insured's DOB: _________________________
(if different from patient)

Authorization#_____________________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 dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Signature:______________________________ Date: ___________________________

After 30 days unpaid balances will be charged interest at a rate of 1.5% per month.

Patient Signature:______________________________ Date: ___________________________