Allied Eye Physicians & Surgeons

PATIENT INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security #:**
City:	**Sex:**
State: **Zip:**	**Referring Physician:**
	Prim. Care Physician:
Home Phone #:	**Emergency Contact:**
Work Phone #:	**Emergency Phone #:**
Cell Phone #:	**Emergency Relationship:**

Responsible Party INFORMATION (If different from Patient)

Name:	**Guarantor Home Phone:**
Address:	**Guarantor Work Phone:**
City:	**Guarantor Cell Phone:**
State: **Zip:**	**Guarantor Birth Date:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate #:	**Certificate #:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber Birth Date:	**Subscriber Birth Date:**
Relationship to Patient:	**Relationship to Patient:**

Authorization for Treatment: I authorize examination, diagnosis, and general treatment, including the use of x-rays and other non-invasive procedures such as diagnostic tests [including treatment of minors (under the age of 18)], to be performed by Allied Eye Physicians and Surgeons providers and staff.

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Allied Eye Physicians and Surgeons, when they accept assignment. I authorize release to the Health Care Financing Administration or its intermediates any information needed for a Medicare claim. I assign the benefits payable for covered Medicare services to Allied Eye Physicians and Surgeons.

I realize this bill is my responsibility, and I agree to pay the balance remaining after my insurance benefits have been paid.

Authorization to Release Medical Information. I hereby authorize my Provider, Allied Eye Physicians and Surgeons, to release any information necessary for my course of treatment.

I understand and accept these terms. If I refuse treatment or leave the facility, I hereby release Allied Eye Physicians and Services from responsibility for my action. These authorizations will remain in effect until Allied Eye Physicians and Surgeons receives notification of revocation.

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Signed (patient or parent if minor) Date