LASER EYE SURGERY OF ERIE DATE_____

LAST NAME FIRST NAME MIDDLE

Name:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone_____ Age:_____

Sex: M:____ F:____ Student? FT:____ PT:____Marital Status: Married: ___ Single:___ Widowed:___ Divorced:___

Employer's Name:_____ E-MAIL ADDRESS_____

Employer Address:_____ City:_____State:_____ Zip:_____Work Phone#:_____

Social Security #:_____-_____-_____ EMERGENCY CONTACT_____PHONE_____

Primary Care Doctor (First & Last Name) _____ Address:_____

Referring Physician:_____ Referral Phone #:_____

Parent / Guardian / Spouse Information

Name:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone #_____ Work Phone #_____ SS#: _____-_____-_____

Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Primary Insurance:

Name of Insurance:_____ ID#:_____

Insured's Name:_____ Group #:_____

Insured's Date of Birth:_____ Insured's SS#:_____-_____-_____

Employer's Name_____

Secondary Insurance:

Name of Insurance:_____ ID#:_____

Insured's Name:_____ Group #:_____

Insured's Date of Birth:_____ Insured's SS#:_____-_____-_____

Employer's Name_____

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Laser Eye Surgery of Erie for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Laser Eye Surgery of Erie for any services furnished me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date