INSURANCE AUTHORIZATION INFORMATION

ALL FIELDS MUST BE FILLED OUT

PATIENT INFORMATION

Name _____ Date of Birth _____

Social Security # _____

Address _____ City & State _____ Zip _____

Primary No: _____ Alternate No:_____

E-mail Address _____

What is your relationship to the Policy Holder? ____Self ____Spouse _____Child ____ Other
(If the patient is NOT the policy holder, the next section MUST be completed in order for us to file your insurance)

POLICY HOLDER INFORMATION

Name _____ Date of Birth _____

Social Security # _____

Employer _____

Name of Medical Insurance _____ Phone# for Customer Service_____

ID# _____ Group# _____

How did you hear about us? (Please check) ____Mailer ____Insurance ____Internet
_____Patient Referral (Name) _____ _____

Insurance Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all charges whether or not paid by insurance. I also authorize the physician to release any information required to process all claims.

Patient or authorized person's signature _____ Date _____

STAFF USE ONLY

Staff Initial: _____

Date: _____

Effective Date of Coverage _____
In Network Benefits: Co-Pay: $ _____
Deductible: $ _____ Met: Yes ___ No ___ Amount: $ _____
Diagnostic Testing: Yes ___ No ___ % Plan pays after deductible met: _____
Referrals Required: Yes ___ No ___
Routine Vision: Yes ___ No ___ Co-Pay: $ _____
Comments _____