MID ISLAND EYE
PHYSICIANS & SURGEONS

PATIENT INFORMATION FORM

PATIENTS NAME _____ SEX: M F BIRTH DATE: ____/____/____

ADDRESS _____ EMPLOYER/SCHOOL _____

CITY, STATE _____ ZIP CODE _____ MARITAL STATUS: M S D W

HOME PHONE _____ WORK PHONE _____ SOCIAL SECURITY # _____

RESPONSIBLE PARTY PRIMARY CARE DOCTOR: _____

PERSON RESPONSIBLE _____ SS # _____

ADDRESS _____ PHONE _____

CITY, STATE _____ ZIP CODE _____ RELATIONSHIP TO PT: Self Spouse Child Other _____

PRIMARY INSURANCE COMPANY

NAME OF INSURANCE COMPANY _____ POLICY # _____ GROUP# _____

ADDRESS TO SEND CLAIMS _____ GROUP NAME _____ COPAY AMOUNT _____

CITY, STATE _____ ZIP CODE _____ PATIENT RELATIONSHIP TO THE POLICY HOLDER: Self Spouse Child Other _____

POLICY HOLDER _____ POLICY HOLDER'S DOB ____/____/____ SS# _____

POLICY HOLDER'S EMPLOYER _____ EMPLOYER'S ADDRESS _____

CITY, STATE _____ ZIP CODE _____

SECONDARY INSURANCE COMPANY

NAME OF INSURANCE COMPANY _____ POLICY # _____ GROUP# _____

ADDRESS TO SEND CLAIMS _____ GROUP NAME _____ COPAY AMOUNT _____

CITY, STATE _____ ZIP CODE _____ PATIENT RELATIONSHIP TO THE POLICY HOLDER: Self Spouse Child Other _____

POLICY HOLDER _____ POLICY HOLDER'S DOB ____/____/____ SS# _____

RELEASE OF INFORMATION

I AUTHORIZE the release of any information necessary to process insurance claims. I also authorize payment of benefits to the physician or supplier for services rendered.

Signature _____ Date _____

MEDICARE PATIENTS

I AUTHORIZE any holder of medical or other information about me to release to THE SOCIAL SECURITY ADMINISTRATION and HEALTH CARE FINANCING ADMINISTRATION or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this AUTHORIZATION to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is MANDATORY to notify the health care provider of any other party who may be responsible for paying for my treatment.