

# Advanced Ophthalmology Inc.

## PERSONAL INFORMATION (Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  M /  F Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip  
Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  
Primary Care Physician: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Referred By: \_\_\_\_\_

## Complete if under 18 years or a student

Name of Father \_\_\_\_\_ Name of Mother \_\_\_\_\_  
Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Medicare # \_\_\_\_\_  Medicaid # \_\_\_\_\_  
 Workers Compensation (job injury) to whom is bill to be sent? \_\_\_\_\_  
 Other Medical Insurance \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_

2nd Insurance \_\_\_\_\_

**INSURANCE POLICY HOLDER:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_  M /  F **Social Security #** \_\_\_\_\_

Who to notify in emergency (nearest relative or friend)?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**Signed** (Patient or parent if minor) \_\_\_\_\_ Date \_\_\_\_\_