University Eye Specialists, PC – Patient Information 18 Years & Under

Patient Name _____
Title Last MI First

C/O _____ **Your SS#** _____-_____-_____
Name of person patient resides with

Your Address _____ City _____

State _____ Zip _____ County _____

Home Phone (_____) _____ Work (_____) _____

Emergency Contact _____ Phone (_____) _____

Patient SS# _____-_____-_____ **Birth Date** _____/_____/_____

Gender: Male Female **Marital Status**: Single Married Widowed Divorced Separated

Primary Physician _____ Phone (_____) _____

Referring Physician _____ Phone (_____) _____

Primary Medical Insurance: Subscriber Information – Relationship to patient _____

Subscriber _____ DOB ____/____/____ SS# _____-_____-_____

Subscriber's Address _____

Insurance Company _____
Present your card to receptionist to copy

Secondary Medical Insurance: Subscriber Information – Relationship to Patient _____

Subscriber _____ DOB ____/____/____ SS# _____-_____-_____

Subscriber's Address _____

Insurance Company _____
Present your card to receptionist to copy

Vision Insurance: Are you eligible **today** for a vision exam benefit? _____yes _____no

Insurance plan to bill _____ ID# _____

The above information is true and complete to the best of my knowledge and belief. I understand I am responsible to pay the cost of care provided by University Eye Specialists should any of the above information be incorrect. I understand that if I have an HMO and do not get a valid referral, I will be responsible for payment. I may also be responsible for the co-insurance and/or applied deductible amount. By signing this I give University Eye Specialists permission to bill my insurance.

***** Please note if your account becomes past due, you will be responsible for collection costs and/or attorney fees. *****

_____ _____
Patient or Guardian Signature **Date**