

# Patient Information

(Please print)

Date

Chart

**PATIENT INFORMATION**

First Name  MI  Last Name

Email  Cell #

Birthdate  Age  Social Security #

Address  City  State

Zip Code  Home #  Sex: Male  Female

Employer  Work #

Spouse  Phone #

Referred By: Family  Friend  Doctor  Other

**EMERGENCY CONTACT**

Name  Work #  Cell #

**INSURANCE INFORMATION**

Primary  Group #  ID #

Name of Insured  Relationship

Secondary  Group #  ID #

Name of Insured  Relationship

Vision  Group #  ID #

Name of Insured  Relationship

Primary Care Physician  Phone #

**ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR TREATMENT:**

I authorize Fogg, Maxwell, Lanier & Remington EyeCare to treat the patient above, authorize the release of any medical information necessary to process this claim and request payment of benefits to Fogg, Maxwell, Lanier & Remington EyeCare.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**MEDICARE LIFETIME SIGNATURE ON FILE:**

I request that payment of authorized Medicare and or Medicare Replacement benefits be made on my behalf to Fogg, Maxwell, Lanier & Remington EyeCare for any service furnished to me by the physicians.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_