Fogg, Maxwell, Lanier & Remington EyeCare

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: _____