EYES, P.A.

NEW/UPDATED PATIENT INFORMATION

Name:_____ **Date**:_____

Birthdate: _____ **Social Security #**_____

Mailing Address: _____ **City**: _____ **State**:_____ **Zip**: _____

Phone: Home:_____ **Cell**:_____ **Work**:_____

Parent or Guardian's Name If Patient Under 18:_____

Alternate Contact Name:_____ **Phone Number**:_____

Relationship: ☐ SPOUSE ☐ PARENT ☐ FRIEND ☐ CHILD ☐ SIBLING ☐ OTHER_____

☐ **Check here to give Eyes, P.A. Staff permission to speak with your alternate contact regarding your health issues**

Who referred you or how did you hear about us?_____

How do you plan to pay for your examination? ☐ **Self-Pay** ☐ **Medical Insurance**

What pharmacy do you use? _____ In what town? _____

Current Occupation/ Employer:_____

INSURANCE INFORMATION

Please bring your insurance card to be scanned into our system

Name of Insured_____ Relationship to Patient_____

Primary Insurance_____ Effective Date_____

Identification #_____ Group #_____

Secondary Insurance_____ Effective Date_____

Identification #_____ Group #_____

All professional services rendered are charged to the patient. Requests for payment from your insurance company will be submitted; however you are responsible for all fees, regardless of insurance coverage. Should your account be delinquent, a collection charge may be added to the outstanding balance. We ask for payment of services when rendered unless other arrangements have been made in advance.

I hereby authorize Eyes, P.A. Dr. Michael Gonyea, Dr. Kenneth Wich, and or Dr. Jessica Barbay to furnish information to my insurance carriers concerning my diagnosis and treatment.

Signature: _____ Date: _____

I hereby assign Eyes, P.A. Dr. Michael Gonyea, Dr. Kenneth Wich, and or Dr. Jessica Barbay all payments for vision and medical services rendered to me and or my dependents. I understand that I am responsible for any balance not covered by my insurance.

Signature: _____ Date: _____