Southside Eye Care ADULT INFORMATION

Were you referred yes__ no__ **Referring Doctor** _____ **General Physician** _____

Patient name_____ Sex____Age____DOB____/____/____
First M.I Last
SS#_____ Height_____Weight_____ Address_____

_____ZIP_____Language_____Race_____Ethnicity_____

Employer_____ Occupation_____ Employer Address _____

Employer Phone_____

Email _____ Home Phone _____Cell Phone _____

Spouse's name _____ Spouse's Employer _____ Phone _____

Emergency Contact _____
Name Relationship Phone

INSURANCE INFORMATION ***Patients with no insurance must pay in full at the time of appointment. Co-pays or charges not covered by insurance are due at the time of visit. **We are UNABLE to bill your insurance without your insurance cards and identification***

Primary ins: _____I.D.#_____

Group #_____Subscriber _____DOB___/_____/_____

Relationship to patient_____

Secondary ins: _____I.D.#_____

Group #_____Subscriber _____DOB___/_____/_____

Relationship to patient_____

Tertiary ins: _____I.D.#_____

Group #_____ Subscriber _____DOB___/_____/_____

Relationship to patient_____

INSURANCE FINANCIAL POLICY

Patients are responsible for any balance due if insurance does not pay for any reason Patients are responsible for any pre-authorizations and/or referral forms required for payment *We will not become involved with any dispute you might have with your insurance company *Past due accounts may be subject to a 40% collection fee if referred to a collection agency.

I, the patient/guardian, have accurately and truthfully completed the above information and agree that all fees incurred are my responsibility regardless of insurance coverage. I certify that I have read and agree to the patient information and privacy policy of this office.

Signature _____Date _____