

**SOLINSKY EYECARE, LLC - PATIENT INFORMATION****PERSONAL INFORMATION (Please print)**

Today's Date

**NAME**

First

Last

Age

M/F

Date of Birth

Soc Sec #

**ADDRESS**

Street

City

State

Zip

**PHONE**

Home

Cell

Work

E-MAIL

**EMPLOYER****OCCUPATION****ADDRESS**

Street

City

State

Zip

**SPOUSE NAME****SPOUSE EMPLOYER****IF PATIENT IS UNDER 18 YEARS OF AGE OR A STUDENT****LEGAL GUARDIAN'S NAME**

First

Last

**EMPLOYER**

Phone #

**ADDRESS**

Street

City

State

Zip

SCHOOL CURRENTLY ATTENDING

**INSURANCE INFORMATION:**

Primary Insurance:

ID#

Group #

Insured's Name:

Insured's Date of Birth:

Insured's Social Security #:

Insured's Employer:

Secondary Insurance:

ID#

Group #

Insured's Name:

Insured's Date of Birth:

Insured's Social Security #:

Insured's Employer:

Are you personally responsible for payment?

 Yes No If No, Who is?**NAME****RELATIONSHIP**

Phone

**ADDRESS**

Street

City

State

Zip

**REFERRAL INFORMATION**

Who referred you to our office?

Doctor/Friend/Relative (Name)

Ins. Plan

Newspaper

Yellow Pages

Other

Who is your Primary

Care Doctor?

City

State

Zip

**FINANCIAL ASSIGNMENT AND AGREEMENT**

Please remember that insurance is considered a method of reimbursing you for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, and any other balance not paid for by your insurance.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

"I hereby acknowledge that I have been offered a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office manager. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way.

Patients or Representative Name (please print)

Patient or Representative Signature

Date

 Patient refused to sign Patient was unable to sign because