Patient Information

Date:___________________ **How did you hear about us?** Friends/family TV
Radio Newspaper Yellow Pages Internet
Referred by Doctor:____

Patient's Name:____

Address:____
City:_______________________________ State:______ County:________________ Zip:______________
Phone #s: Home: (____)-__________ Work: (____)-__________ Cell phone: (____)-______________
E-mail:____
Birthdate:______________________ Age:_________ Social Security #:____________________
Marital Status: Single Widowed Married Divorced

Employer:____

Employer's Address:____
City:___________________________ State:________ Zip:______________

Spouse Information: Name:____
DOB:_______________________________ Social Security #:_____________________________
Employer:_______________________________________ Phone: (______)______________________
Address:____
City:_____________________________________ State:________ Zip:____________________

Emergency Contact (not living in the same household):____________________________
Relationship:____________________________________ Phone: (______)______________________
Address:____
City:_____________________________________ State:________ Zip:____________________

Person (s) we may talk with on your behalf regarding appointments, medicines, questions about care, etc.

Name:____

Relationship:____

Preferred Pharmacy Name:________________________________

Address:____________________ Phone #:____________________

Medicare #:____________________ **Medicaid #:**____________________

Name of Insurance Company (Primary):________________________________

Name of Policy Holder (if other than yourself):________________________________

Policy Holder's Social Security #:________________ Policy Holder's Date of Birth:________________

Policy #:____________________ Group #:____________________

Insurance Company Claims Address:________________________________

Name of Insurance Company (Secondary):________________________________

Name of Policy Holder (if other than yourself):________________________________

Policy Holder's Social Security #:________________

Policy Holder's Date of Birth:________________

Policy #:____________________ Group #:____________________

Insurance Company Claims Address:________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Schulze Eye Center, P.C. and/or Schulze Surgery Center, Inc., all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

I further authorize Schulze Eye Center, P.C. and/or Schulze Surgery Center, Inc. to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

Financial Agreement

I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature:________________________ Date:____________________

Printed Name:________________________________

Relationship to Patient:________________________________

Witness:________________________ Date:____________________