Eye Associates of Green Bay, SC

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PATIENT INFORMATION FORM

Patient Name _____ Gender _____ ☐S ☐M ☐W ☐D

Last First Middle Initial Marital Status

Social Security _____ Primary Care Physician _____

Date of Birth _____ Home Phone _____

Mailing Address _____ Cell Phone _____

Physical Address _____ Work Phone _____

City/State/Zip _____ Email Address _____

Employer _____ Permission to use e-mail: ☐YES ☐NO

Spouse/Significant Other _____ Day Phone _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____

PRIMARY INSURANCE

Name of Insurance _____ Subscriber's SS# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Patient's Relationship to Subscriber _____

ID Number _____ Group Number _____

SECONDARY INSURANCE

Name of Insurance _____ Subscriber's SS# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Patient's Relationship to Subscriber _____

ID Number _____ Group Number _____

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I authorize EYE ASSOCIATES OF GREEN BAY, SC to release any demographic information needed for surgery or tests. I have read and understand the EYE ASSOCIATES OF GREEN BAY, SC Financial Policy. I accept full responsibility for the medical charges incurred by the patient and agree to pay bills in full at the time of service unless other arrangements are made. I authorize EYE ASSOCIATES OF GREEN BAY, SC to release any information needed to process insurance claims. I also authorize payments from my insurance claim to be paid directly to EYE ASSOCIATES OF GREEN BAY, SC. I understand Financial Counselors are available if I have questions or concerns about my financial responsibilities.

Signature _____ Date _____

Initial _____ Date _____ Initial _____ Date _____ Initial _____ Date _____