



PERSONAL INFORMATION: (Please Print)

Name _____ Date _____

Date of Birth _____ Age ____ Sex M / F Soc Security # _____

Street Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Phone: Home (____) _____ Work (____) _____

Occupation _____ Employer _____

Address _____ Phone (____) _____

Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced

Spouse Name _____ DOB _____ Employer _____

Address _____ Phone (____) _____

Complete if under 18 years or a student

Name of Father _____ DOB _____ Employer _____

Address _____ Phone (____) _____

Name of Mother _____ DOB _____ Employer _____

Address _____ Phone (____) _____

HOW DID YOU HEAR ABOUT OUR OFFICE?:

____ Friend/Relative _____ Doctor _____

____ Yellow Pages ____ Newspaper ____ Other _____

INSURANCE INFORMATION:

Do you have a Vision Plan ? _____

____ Medicare # _____ Medicaid # _____

____ Workers Compensation (job injury) to whom is bill to be sent? _____

____ Other _____ Group # _____ ID# _____

Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? Yes / No If not, who is?

Name _____ Relationship _____ DOB _____

Person to notify in emergency (nearest relative or friend):

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO OFFICE PARK EYE CENTER ALL BENEFITS, OF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I, ALSO, AUTHORIZE THIS OFFICE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

I, ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENT/GUARDIANS ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE PAYMENT. 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.

Signed (Patient or parent if minor) _____ Date _____