NEW PATIENT INFORMATION

DATE____________________

NAME____ E-MAIL ADDRESS________________
LAST FIRST MIDDLE INITIAL

ADDRESS____
STREET CITY STATE ZIP

HOME#________________________ CELL #______________________________ WORK #________________

SOCIAL SECURITY #__________________________ AGE________ BIRTHDATE________________ MALE FEMALE

OCCUPATION____________________________________ EMPLOYER________________________________

PRIMARY INSURANCE______________________________ POLICY #________________________________

SECONDARY INSURANCE ___________________________ POLICY #________________________________

VISION INSURANCE_______________________________ POLICY #________________________________

MARITAL STATUS_________________________________ SPOUSE'S NAME___________________________

SPOUSE'S BIRTHDATE_____________________________ SPOUSE'S EMPLOYER_______________________

SPOUSE'S SOCIAL SECURITY #_______________________ SPOUSE'S WORK #_________________________

PARENT OR GUARDIAN NAME________________________ S.S.#____________________ BIRTHDATE____________

EMERGENCY CONTACT_______________________________________ PHONE #____________________________

FAMILY PHYSICIAN____ PHONE #____________________________

IF YOUR INSURANCE COVERAGE IS THROUGH A SPOUSE OR OTHER FAMILY MEMBER YOU MUST FILL OUT THIS SECTION COMPLETELY

INSURED'S NAME____ RELATIONSHIP_________________________

S.S.#____________________ DOB______________ HM #____________________ WK #_________________________

EMPLOYER NAME____

INSURANCE POLICY____ POLICY #____________________________

CO-PAYMENTS AND DEDUCTIBLES FOR INSURANCE MUST BE PAID AT TIME OF SERVICE

I hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare and other governmental sponsored programs, private insurance, and any other health plans to which I am entitled to MEDICAL VISION TECHNOLOGY OPTHAMOLOGY GROUP, INC. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits, including Medicare under Title XVIII of the Social Security Act.

I understand that I am financially responsible for all charges whether or not paid by insurance, including any deductible amount, co-insurance or non-covered services.

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SIGNATURE OF PATIENT OR GUARDIAN