PLEASE PRINT CLEARLY

TODAY'S DATE:____________________________ AGE:__________ MARITAL STATUS: (S M W D)

DATE OF BIRTH:____________________________ SOCIAL SECURITY NUMBER:______________________________

PATIENT'S NAME:____NICKNAME:________________________SEX: (M F)

ADDRESS:____

Street City State Zip

HOME PHONE:__(_____________)____________________________WORK PHONE:__(___________)________________

CELL PHONE:__(_____________)____________________________E MAIL ADDRESS:___________________________

EMPLOYER:____OCCUPATION:_____________________________
____

WORK ADDRESS:____

Street City State Zip

EMERGENCY CONTACT:____

Name Phone Relation

INSURANCE INFORMATION

PRIMARY INSURANCE:__________________________________POLICY HOLDERS NAME___________________________

SOCIAL SECURITY NUMBER:_____________________________________DATE OF BIRTH:__________________________

POLICY NUMBER:____GROUP NUMBER:__________________________

SECONDARY INSURANCE:________________________________POLICY HOLDERS NAME___________________________

SOCIAL SECURITY NUMBER:_____________________________________DATE OF BIRTH:__________________________

POLICY NUMBER:____GROUP NUMBER:__________________________

HOW DID YOU HEAR ABOUT LARSON EYE CENTER, Ltd.? Please check one of the following:

_______**DOCTOR (NAME**:__________________________________) _______FAMILY _______FRIEND

_______INSURANCE _______WEBSITE _______MAILER _______NEWSPAPER _______PHONE BOOK

_______COMMUNITY EVENT / LECTURE / SEMINAR (Please specify):______________________________________

RELEASE OF INFORMATION-PAYMENT AUTHORIZATION

I request that payment of insurance benefits be made payable directly to Larson Eye Center, Ltd. for any services furnished to me by that provider. I authorize Larson Eye Center, Ltd. to release to my insurance carrier any information needed to determine those benefits or the benefits payable to the related services.

I understand that I am financially responsible for any charges not covered by insurance.

If I default and do not pay, Larson Eye Center, Ltd. is entitled to the right of recovery of all collection expenses up to 33%, including all court costs and reasonable attorney's fees incurred for the purpose of securing payment.

This authorization is in effect until I choose to revoke it.

____ ____________________________

Signature of Patient **Date**