



PATIENT INFORMATION

Dr. Mr. Mrs. Ms. _____ Date _____
(First) (M.I.) (Last)

Marital Status: Single Married Widowed Divorced Sex: Female Male

Address _____ Apt# _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Home Phone _____

Driver's License # _____ State _____ Occupation _____

Employer _____ Work Phone _____ Cell Phone _____

Hobbies _____ Email _____

Who referred you to our office? _____ *(We would like to thank them)*

Spouse's Information - Name _____ Employer _____ Work Phone _____

Who to Contact In Emergency _____

Relationship _____ Phone _____

Name of nearest relative not living with you _____

Relationship _____ Phone _____

INSURANCE INFORMATION

Medicare Number _____ Medicaid Number _____

Other Insurance _____ Policy Number _____

Primary Cardholder's Name _____ Group Number _____

Cardholders Date of Birth _____ Social Security # _____

AUTHORIZATION FOR EXAMINATION AND FILING OF INSURANCE CLAIMS

I authorize and request examination by a physician of Carter Eye Center or their staff. I authorize the performance of whatever procedures the judgment of above named staff may deem necessary during the treatment. I also authorize the administration of any anesthetics and analgesics (including eye drops) which the above staff deem advisable. I may request that any procedure not be performed.

I understand that if I have HMO coverage that requires physician referral for examination or surgery that I am responsible for obtaining the referral. I also understand that if I do not obtain my referral before the service is rendered, I am financially responsible for the charges.

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Carter Eye Center/Carter Optical for any services furnished me. I also authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services

Patient's Signature _____ Date _____