PATIENT INFORMATION

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thank you.

NAME: ____

ADDRESS: ____

CITY:_____________________ STATE: ______ ZIP: _____________

HOME PHONE: (_____) __________ X ________

WORK PHONE:___________________________

BIRTHDATE: __________________ MARITAL STATUS:____

SOCIAL SECURTIY NUMBER: ______ - ____ -_______

OCCUPATION/GRADE: ____

EMPLOYER/SCHOOL: ____

PRIMARY INS: ____

PATIENT PRIMARY ID #: ______________________________________

PRIMARY SUBSCRIBER: _________________________BIRTHDATE: ___________

SUBSCRIBER PRIMARY ID #: ____________________________________

SECONDARY INS:____

PATIENT SECONDARY ID #: ______________________________________

SECONDARY SUBSCRIBER: ________________________ BIRTHDATE: ___________

SUBSCRIBER SECONDARY ID #: ___________________________________

EMAIL ADDRESS:

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished me be made on my behalf to Barry Morrison, O.D.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X____ ________________
Date