Alaska EYE CARE CENTERS, APC

PATIENT INFORMATION

DATE: ____________________

ACCOUNT #: ____________________

PATIENT'S NAME____________________ Sex: o Male o Female

Date of Birth (mm/dd/yyyy)____________________ Social Security Number ____________________

Mailing Address____________________ City____________________ State______ Zip ________

Physical Address____________________ City____________________ State______ Zip ________

Employer____________________ Occupation____________________ E-mail ____________________

Telephone No. (Home)____________________ (Cell)____________________ (Work) ____________________

Emergency contact or nearest relative not living with you. (Name) ____________________

Phone No.____________ Address____________________ City__________ State_____ Zip ________

MEDICAL INSURANCE INFORMATION

Relationship to Insured o Self o Spouse o Dependent Child o Other

POLICY HOLDER____________________ Sex: o Male o Female

Date of Birth ____________________ Insurance ID Number ____________________

Telephone No. (Home)____________________ (Work) ____________________

Employer____________________ Occupation ____________________

PRIMARY INSURANCE COMPANY____________________ Phone No. ____________________

Address____________________ City__________ State______ Zip ________

Group No.____________________ Policy No. ____________________

SECONDARY INSURANCE COMPANY____________________ Phone No. ____________________

Address____________________ City__________ State______ Zip ________

Group No.____________________ Policy No. ____________________

Policy Holder____________________ Date of Birth __________ Insurance ID Number ____________________

Employer____________________ Home Phone____________________ Work Phone ____________________

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment be made on my behalf to **Alaska Eye Care Centers, APC** for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorize my doctor to act as my agent, as above.

Date____________________ Signature ____________________

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS A MINOR

Name____________________ Sex: o Male o Female

Date of Birth____________________ Social Security Number __________

Relationship ____________________

Employment Status o Employed o FT Student o PT Student

Mailing Address____________________ City__________ State______ Zip ________

Physical Address____________________ City__________ State______ Zip ________

Telephone No. (Home)____________________ (Work) ____________________

Employer____________________ Occupation ____________________

I HEREBY AUTHORIZE THE REPRESENTATIVES OF ALASKA EYE CARE CENTERS, APC TO RENDER WHATEVER SERVICES ARE NECESSARY FOR THE CARE OF MYSELF, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AND THAT ALL CHARGES ARE DUE AT THE TIME OF SERVICE. I WILL FURNISH INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO TREATMENT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. (MONTHLY FINANCE CHARGES WILL BE ASSESSED FOR ACCOUNT BALANCES OVER 60 DAYS UP TO THE MAXIMUM AMOUNT ALLOWED BY LAW.)

Date____________________ Signature ____________________

PHARMACY OF CHOICE ____________________ **Address** ____________________