Patient Information Sheet

NAME _____ SEX M_____ F _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ CELL PHONE # _____

OCCUPATION _____ BIRTH DATE _____

SOCIAL SECURITY # _____ AGE _____

SPOUSE/ PARENT NAME _____

FAMILY PHYSICIAN _____ ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU TO US ? _____

INSURANCE _____ INSURED'S NAME _____

Patient's or Authorized Person's Signature

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

SIGNED _____ DATE _____

Insured or Authorized Person's Signature

I request that payment of authorized medical insurance benefits may be made payable on my behalf to Mayfair Eye Associates for any services furnished and I agree to be responsible for any balances that are not covered by my insurance co.

SIGNED _____ DATE _____