PATIENT INFORMATION

NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

HOME PHONE: **CELL:**

WORK PHONE:

BIRTHDATE: **MARITAL STATUS:**

SOCIAL SECURITY NUMBER:

OCCUPATION/GRADE:

EMPLOYER/SCHOOL:

EMAIL ADDRESS:

INSURANCE INFORMATION

INSURANCE CO.	ID NUMBER	SUBSCRIBER	SUBSCRIBER ID	SUBSCRIBER BIRTHDATE
VISION				
MEDICAL				

ACKNOWLEDGMENT OF RECEIPT OF HIPPA/PRIVACY POLICIES

I acknowledge that I have received a copy of the Notice of Privacy Practices for this office.

X____ Date________________________

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Brownsburg Family Eye Care, P.C.

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________________________