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FAMILY EYE PHYSICIANS

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print*. All information will be kept confidential.*

PATIENT INFORMATION

Date: ___________________________ Cell Phone: _______________________________ Home Phone: _________________________________

Patient Name: ____ SSN# ________-_______-_________
Last Name First Name Middle Initial

Street Address: ____

City____ State___________ Zip Code____________ E-Mail________________________________

Sex ☐ M ☐ F Age________ Birthdate_____/_____/______ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's or parent's employer: ____ Work Phone______________________________

Business Address___________________________________ City______________________________ State_________ ZIP__________________

Who may we thank for referring you? ____

Family Doctor____ Phone___________________________

In case of emergency who should be notified? ____ Phone________________________

PRIMARY INSURANCE

Name of person responsible for this account: ____ Birthdate_______/______/_________

Relationship to Patient: ____________________________________ Soc. Sec. #____

Address (if different from patient's)____ City________________ State_______ Zip____________

Subscriber employer____ Work Phone________________________________

Insurance Company____

Subscriber ID #____________________________________ Group #______________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name __________________________________ Birthdate______/_____/________ Relation to patient__________________________

Address (if different from patient's)____ City__________________ State______ Zip___________

Subscriber employer____ Work Phone_____________________________

Insurance Company____

Subscriber ID #____ Group #_________________________ SSN #__________________________

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with _________________________________ and assign directly to
Name of Insurance Company
Dr. Al-Khudari all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

____ ___________________________________ __________________________
Responsible Party Signature Relationship Date