RENAISSANCE EYE CARE

PATIENT INFORMATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address/P.O. box:	Social Security no.:	Home phone no.: ( )

Cell phone no:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose/Referred to Renaissance Eye Care by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet search	❑ Other:

e-mail address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here?	❑ Yes ❑ No		

Social Security #:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Specialist Co-pay: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Renaissance Eye Care** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*