Eye Consultants
OF PENNSYLVANIA, PC

Date: _____

Patient's Name: _____ Patient's Account #: _____

Patient's Social Security #: _____ Patient's Date of Birth: _____

Spouse's Name: _____ Spouse's Social Security #: _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance: _____

Address of Primary Insurance: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance: _____

Address of Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID NUMBER: _____ GROUP NUMBER: _____

VISION INSURANCE INFORMATION

Name of Vision Insurance: _____

Address of Vision Insurance: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID NUMBER: _____ GROUP NUMBER: _____

In case of emergency, who should we notify?

Name: _____

Address: _____ Telephone Number: _____

ASSIGNMENT AND RELEASE

I hereby authorize EYE CONSULTANTS OF PENNSYLVANIA, P.C. to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly to EYE CONSULTANTS OF PENNSYLVANIA, P.C. of the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of this account.

Signed: _____ Date: _____

(Patient or Parent if Minor)