OFFICE USE ONLY

_____/_____/_____
Today's Date

CENTRAL FLORIDA EYE CARE, LLC

_____
Chart Number:

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First) _____ (MI)

Gender: ☐ Male ☐ Female

_____/_____/_____
Date of Birth:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

_____
Social Security Number

_____
Email Address:

Home Address: _____

_____ (City) _____ (State) _____ (Zip)

(_____) _____
Home Phone:

(_____) _____
Work Phone:

(_____) _____
Cell Phone:

Mailing Address (If other than Home Address): _____

_____ (City) _____ (State) _____ (Zip)

_____
Referred to our office by:

☐ Doctor
☐ Family/Friend
☐ Newspaper
☐ Yellow Pages

Family Doctor: _____
Name

_____
Clinic or City:

(_____) _____
Phone:

EMPLOYMENT INFORMATION

Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Employer Address: _____

_____ (City) _____ (State) _____ (Zip)

(_____) _____ X _____
Employer Phone: Ext:

EMERGENCY CONTACT INFORMATION

Person to Contact in Case of Emergency: _____ (Last) _____ (First) _____ (MI)

_____
Relationship:

(_____) _____
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Responsible Party (If other than Patient): _____ (Last) _____ (First) _____ (MI)

_____
Address

_____ (City) _____ (State) _____ (Zip)

_____
Relationship:

(_____) _____
Responsible Party Phone:

(_____) _____
Responsible Party Cell Phone:

INSURANCE INFORMATION

Primary Insurance

_____
Primary Insurance Company:

Claims Address: _____

_____ (City) _____ (State) _____ (Zip)

Policy Holder Name: _____ (Last) _____ (First) _____ (MI)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

_____ (Social Security Number) _____ (Date of Birth)

ID No:_____ Group No: _____

Secondary Insurance

_____
Secondary Insurance Company:

Claims Address: _____

_____ (City) _____ (State) _____ (Zip)

Policy Holder Name: _____ (Last) _____ (First) _____ (MI)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

_____ (Social Security Number) _____ (Date of Birth)

ID No:_____ Group No: _____

The undersigned hereby authorizes CENTRAL FLORIDA EYE CARE, LLC and Dr. Scott Klein to apply for benefits on my behalf for covered services rendered, and to request payments from my insurance carriers be made directly to CENTRAL FLORIDA EYE CARE, LLC and/or to Dr. Klein. I certify that the information I have reported is correct, and I authorize CENTRAL FLORIDA EYE CARE, LLC to release any necessary information, including medical information, for this and any related claim to insurance carriers, in order to determine benefits to which I am entitled. I also hereby assign to CENTRAL FLORIDA EYE CARE and to Dr. Klein all payments for medical services rendered to me and/or to my dependents. I understand that I am financially responsible for all charges (including equipment and/or supplies) not covered by this assignment (whether or not paid by said insurance). A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in wiring. All co-pays, non covered services, and deductibles will be due at the time of service

_____ _____
Patient / Responsible Party Signature Date