Newport Eye Center
1401 Avocado, Suite 505, Newport Beach, CA 92660 (949) 644-0239

Patient Information Sheet

Last Name _____ First Name _____ Middle Initial _____ Date _____

Date of Birth _____ Age _____ SSN _____

Marital status: Single _____ Married _____ Divorced _____ Widowed _____

Home Address _____ City _____ State _____ Zip _____

Phones:

Home/Cell ( ) _____ Work ( ) _____

If minor, use parental information to complete the next section.

Employer _____ Occupation _____

Work Address _____

Name of spouse or parent if minor _____

Family Physician _____ Referred by _____

Insurance information:

	Name:	Policy #:	Group #
1.			
2.			

Patient's Extended Signature Authorization *(permit payment of benefits to supplier, physician, or patient.)*

A. MEDICARE

The same regulation in effect since April 1, 1982 allows physicians to obtain from beneficiaries and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims in the beneficiaries behalf.

The beneficiary must sign a brief statement as follows:

_____ _____
Name Insurance Claim No.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Newport Eye Center, or supplier, for any services furnished me by that physician/supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of the medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: / / .

B. OTHER INSURANCES

ASSIGNMENT: I hereby authorize payment directly to above-named physician of the surgical and /or medical benefits, if any, otherwise payable to me for his services as described on this or an attached claim. I realize that this may not represent the fulll payment for services rendered and I will be responsible for the balance due (Insured Person):

Signed: _____ Date: / / .

RELEASE: I hereby authorize above-named physician to furnish any information acquired in the course of my examination to my insurance carriers (Patient, or Parent if Minor):

Signed: _____ Date: / / .