PATIENT INFORMATION FORM

MOSES EYECARE CENTER

Patient Name: _____ Date: _____

SSN _____ DOB: _____ Sex: M / F

Circle One: Single/Married/Divorced/Widow

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____

Employer: _____ Occupation: _____

Email (optional): _____ Would you like communications via text? Y / N

Insurance Policy Holder

☐ Please check box if all of the policy holder's information is the same as the patient information above

Name of Insurance: _____

Policy Holder's Name: _____ DOB: _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____

Responsible Party Signatures

☐ Please check box if all of the responsible party's information is the same as the patient information above.
The following name and information provided will be the party responsible for any financial obligations and/or communications.

Responsible Party Name: _____ DOB: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone: _____

Relationship to patient: PARENT/ LEGAL GUARDIAN/ OTHER (please specify): _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Moses Eyecare Centers. I acknowledge that I am financially responsible for payment not covered by insurance. I understand and accept responsibility for service charges, late fees, and other costs including attorney fees and cost incurred in the collection of this account.

Responsible Party Signature _____ Date: _____