PATIENT'S NAME _____ #_____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

OTHER ADDRESS/EMAIL _____

PHONE (___)_____ AGE _____ DOB _____ SEX_____ S M W D

PERSON TO NOTIFY IN CASE OF EMERG _____ PHONE _____

CURRENT EMPLOYER / RETIREMENT DATE _____ WK PHONE _____

PT SSN# _____ DL COPIED? Y / N REFERRED BY _____

PCP_____

IF UNDER 18 YRS OLD OR A STUDENT:

PARENT NAME _____ PARENT'S EMPLOYER/PHONE# _____

PARENT'S SSN# _____ PARENT'S ADDRESS/PHONE _____

PRIMARY INSURANCE _____ POL# _____

SECONDARY INSURANCE _____ POL# _____

SUBSCRIBER NAME _____ SSN# _____ DOB _____

WORK COMP INSURANCE _____ DOI _____ NOI? Y ES / NO

VERIFIED BY _____ PHONE _____

1 2 3 4 5 6 7 8

I authorize the release of my medical information to the following other people:

_____

If no one is listed, records will only be released to you or as required by law. **Please consider if you wish to allow family members any access to your information.**

Pt Initial _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**

In order to control your cost of billings, we request that your charge for office visits be paid at the conclusion of each visit unless you are covered by Medicare.

I hereby authorize Central Florida Eye Institute/Thomas L. Croley, MD and his assistants to perform such professional diagnostic, laboratory, medical, and surgical procedures as are necessary in his judgment, and to render such care and services as are customary and necessary.

I hereby authorize Thomas L. Croley, MD and his staff to leave any messages pertaining to my medical care at phone numbers listed above. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Central Florida Eye Institute/ Thomas L. Croley, MD for any services furnished by them. I authorize any holder of my medical information to release to the Health Care Financing Administration and any other agent listed above any information needed to determine benefits payable for related services, by mail or fax.

I understand that I am financially responsible for all charges, whether or not paid by my insurance.

_____ _____

Beneficiary Signature (Lifetime)* (parent if pt is a minor) Date