Harris EYE CARE

PATIENT DATA FORM

Please fill out completely and sign bottom in black ink only. Thank you.

Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Birthdate _____ Sex: Male/Female

Cell _____ E-mail Address _____

Marital Status: Single Married Divorced Widowed

Spouse's Name _____

If a minor - Guardian/Parent's Name _____

Insurance Information:
Cardholder's name and relationship to patient _____

SS#_____ Birthdate _____

Are you: Employed Disabled Retired Other _____

If you are retired is your spouse still employed? YES NO

If you are employed - occupation _____

Name of Employer _____

Phone _____ Referred by _____

Alternate contact person - other than home phone number:

Name/Relationship _____ Phone _____

It is my responsibility to provide all necessary insurance information to process payment of my claim. I authorize payment of my insurance benefits to be made directly to my doctor. As a courtesy, the doctor's office will submit may claims to my insurance carriers, but I understand that I am financially responsible for all services rendered not covered or payable by my insurance carrier including deductibles, co-payments or non-covered services.

If I need an authorization/referral, it is my responsibility to obtain it from my primary care physician prior to my appointment or I will be held responsible for payment of services rendered.

Patients who have BCBS Mastermedical, no office visit coverage or have no insurance will be expected to pay in full at the time medical services are rendered.

Signature _____ Date _____

☐ No Changes Signature _____ Date _____

☐ No Changes Signature _____ Date _____

☐ No Changes Signature _____ Date _____

Patient Signature _____ *Date* _____

HEC-14/05