Lakeland Eye Clinic
Care You Can See

PATIENT INFO

Name (Last, First Middle & Maiden)

Street Address

Mailing Address

City / State / Zip

Home Number

Cell Number

Social Security Number

Date of Birth

Age

Sex

Marital Status

Spouse's Name

Work Number

Email Address

RESPONSIBLE PARTY'S SIGNATURE / DATE

HOW WERE YOUR REFERRED

- ☐ Newspaper: _____
- ☐ Yellow Pages: _____
- ☐ Doctor: _____
- ☐ Other: _____

RESPONSIBLE PARTY (If Minor Child)

Responsible Party

Street Address

Primary Number

In Case of Emergency Contact

RESPONSIBLE PARTY (If Minor Child)

Responsible Party

Street Address

Primary Number

In Case of Emergency Contact

EMPLOYER INFORMATION

Employer

Street Address

City / State / Zip

Occupation / Job Title

INSURANCE INFORMATION

Primary Insurance Company

Policy Number / Group Number

Secondary Insurance Company

Policy Number / Group Number

INSURER INFORMATION

If other than card holder

Insurance Company or Insurer

Insurer Name

Date of Birth

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I. MEDICARE LIFETIME SIGNATURE AUTHORIZATION

I request payment of authorized Medicare benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

Date: _____ Signature: _____

II. MEDIGAP SIGNATURE AUTHORIZATION

I request payment of authorized Medigap benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

Date: _____ Signature: _____

III. OTHER INSURANCE SIGNATURE AUTHORIZATION

I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. or authorize such physician or organization to submit a claim to my insurance company for me.

Date: _____ Signature: _____

IV. AUTHORIZATION FOR RELEASE OF INFORMATION

i hereby authorize all physicians, providers, and health care facilities that have provide health care services to me or my dependents to release any information relating to the diagnosis, treatment, or examination rendered. i agree that a photographic copy of this authorization shall be as valid as the original.

Date: _____ Responsible Party Signature: _____

Date: _____ Witness: _____