

IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

OFFICE

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL		SOCIAL SECURITY NO.	
ADDRESS				CITY		STATE	ZIP CODE
HOME PHONE ()	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> M <input type="checkbox"/> W	DATE OF BIRTH	AGE	EMPLOYER		
EMPLOYER'S ADDRESS				CITY		STATE	ZIP CODE
CELL PHONE ()	WORK PHONE ()		OCCUPATION				
I WAS REFERRED TO THIS PRACTICE BY:		<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Family		<input type="checkbox"/> Friend <input type="checkbox"/> Other _____	

RESPONSIBLE PARTY (SKIP IF SAME AS ABOVE)

LAST NAME		FIRST NAME		MIDDLE INITIAL		SOCIAL SECURITY NO.	
ADDRESS				CITY		STATE	ZIP CODE
DATE OF BIRTH	HOME PHONE ()	WORK PHONE ()	OCCUPATION	EMPLOYER			
EMPLOYER'S ADDRESS				CITY		STATE	ZIP CODE

SPOUSE

SPOUSE'S NAME	SPOUSE'S SS#	SPOUSE'S EMPLOYER
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EMERGENCY

EMERGENCY CONTACT AT DIFFERENT ADDRESS	RELATIONSHIP	HOME PHONE ()	EMPLOYER
ADDRESS	CITY		STATE ZIP CODE

INSURANCE

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

INSURANCE CO. #1		INSURANCE CO. #2	
COMPANY NAME		COMPANY NAME	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
ID NO.	SUBSCRIBER'S SOCIAL SECURITY NO.	ID NO.	SUBSCRIBER'S SOCIAL SECURITY NO.
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT	SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by the physicians of James River Eye Physicians and/or any affiliated medical staff member(s). I authorize direct payment from my insurance carrier to this practice. I accept responsibility for payment of all charges incurred as well as reasonable attorney's fees and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE
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MEDICARE PATIENTS ONLY

IF YOU ARE A MEDICARE PATIENT, THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.

BENEFICIARY NAME	HIC NUMBER (POLICY NUMBER)
I request that payment of authorized Medicare benefits be made either to me or on my behalf to James River Eye Physicians, P.C. for any services furnished me by that physician/supplier. 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 or the benefits payable to related services.	
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.	
BENEFICIARY SIGNATURE	DATE