

## PATIENT INFORMATION - PLEASE PRINT

LAST NAME	FIRST NAME	MI	PATIENT'S SOCIAL SECURITY NUMBER		
PATIENT'S DATE OF BIRTH	SEX	MARITAL STATUS			STUDENT STATUS
F   M		S   M   W   DIV   SEP			FULL TIME   PART TIME
STREET ADDRESS	CITY	STATE	ZIP		
RACE (Government requested)					
ASIAN   BLACK   HISPANIC   AMERICAN INDIAN   ALASKAN   WHITE   OTHER					
PRIMARY LANGUAGE (Government requested)					
OCCUPATION					
PRIMARY OPHTHALMOLOGIST			PRIMARY CARE PHYSICIAN		
HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS	CONTACT PREFERENCE	
(   )	(   )	(   )		HOME   CELL   WORK	

## INSURANCE INFORMATION

**PLEASE PRESENT INSURANCE CARDS AT CHECK-IN**

### GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT)

LAST NAME	FIRST NAME	MI	PATIENT'S SOCIAL SECURITY NUMBER		
DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT			STUDENT STATUS
F   M		SELF   SPOUSE   PARENT   OTHER			FULL TIME   PART TIME
HOME ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP	HOME PHONE	
				(   )	

### EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

Please complete reverse side

## INSURANCE AUTHORIZATION

As a courtesy to our patients we will file claims to your insurance company with the information you provide at the time of service. Due to the ever-changing nature of insurance we are unable to guarantee payment by your insurance company. We will be glad to try and help you with your insurance questions but it is ultimately the patient's responsibility to know and follow any policy guidelines and restrictions of your particular policy.

- I understand that I remain financially responsible for all medical fees incurred for services rendered by Iowa Eye Center and agree to pay all charges not covered by insurance and any applicable co-payments and/or deductibles.
  
- I authorize the release of any medical or other information necessary to process insurance claims for services rendered by Iowa Eye Center.
  
- I authorize payment of medical and/or vision benefits directly to Iowa Eye Center for services rendered.

X \_\_\_\_\_

Patient or Authorized Representative

Date

*If you have Medicare please complete the following:*

Are you (or your spouse) currently working?	Yes	No
Are you receiving benefits under an employer's disability policy?	Yes	No
Do you have end stage renal disease?	Yes	No

Statement to Permit Payment of  
Medicare Benefits to Provider,  
Physicians and Patient

Name of Beneficiary \_\_\_\_\_ Medicare # \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Iowa Eye Center, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

