Patient's
Last name : _____ First name : _____ MI : _____

Address : _____

City : _____ State code : ____ Zipcode : _____

Referring Dr:
Phone # : _____ Sex (M/F) : ____ Marital Status : ____ S M D W

Birthday : _____/_____/_____ Social sec : _____/_____/_____

Home Phone : (_____)_____ Work Phone : (_____)_____

Emergency : _____ Emer Phone : (_____)_____

Email : _____ Cell Phone : (_____)_____

== Primary Insurance Coverage ========

Company : _____

Insured name : _____

Relationship : _____ DOB:_____

Co-pay amount : _____

Policy number : _____

Group number : _____

Employer : _____

== Secondary Insurance Coverage ========

Company : _____

Insured name : _____

Relationship : _____ DOB:_____

Co-pay amount : _____

Policy number : _____

Group number : _____

Employer : _____

== Guarantor Information ==========

Guarantor : _____

Address : _____

City : _____ State code : _____ Zipcode : _____

Telephone # : (_____)_____ Miscellaneous : _____

Patient's Authorization

I request the direct payment of authorized medical or vision benefits be made to MD Eyecare LLC for any services furnished me by Drs.Duncan,Minkowski,McGinn or Foley.I authorize any holder of medical information about me to release this information to my insurance carrier [or intermediaries,to CMS and its agent,to my attorney,or to another physician's office.I understand that MD Eyecare LLC reserves the right to charge interest on and/or pursue delinquent accounts via third party collection agencies and that I am responsible for any fees and/or court costs incurred by MD Eyecare LLC during the collection process. Also,I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or my legal dependent I am financially responsible for all charges subject to coverage.

Signature[Seal]_____Date_____