Fifth Avenue
Eye Clinic & Optical

We are pleased to welcome you to our clinic. Please take a few moments to fill out this form. If you have any questions, we are more than happy to help!

PATIENT INFORMATION:

DATE OF SERVICE:_____ PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: **MALE / FEMALE** AGE:_____ DATE OF BIRTH: _____

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: **MARRIED / SINGLE / DIVORCED / WIDOWED / PARTNERED**

CONTACT INFORMATION

PRIMARY PHONE NUMBER: _____

SECONDARY PHONE NUMBER:_____

EMAIL : _____

EMERGENCY CONTACT:

NAME: _____

PHONE: _____

VISION INSURANCE:

POLICY HOLDER NAME: _____

POLICY HOLDER BIRTHDAY: _____

LAST 4 OF SS#: _____

(Please make sure that we have a current copy of your medical insurance card as well. We will only use it in the case of Medical Photos or office visits. Thank you!)

INSURANCE ASSIGNMENT AND RELEASE AGREEMENT

I the undersigned have insurance coverage with _____ and Name of Insurance Carrier
And assign directly to Fifth Avenue Eye Clinic/ Dr. Gale Stead all medical benefits if any otherwise payable to me for the services provided. I understand that I am financially responsible for all charges including the cost of Collection Agency fees, whether my insurance company pays or not. I hereby authorize Fifth Avenue Eye Clinic to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature: _____ Date: _____
(Signature of Patient/Insured/Guardian)