

PATIENT INFORMATION

Welcome to Eye Associates of Northern New England.
In order to serve you properly, we need the following information. **PLEASE PRINT.**

Today's Date: _____

Patient Name: _____ Social Security Number: _____

Mailing Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Other Phone: _____

Date of Birth: _____ Male Female **Primary Care Physician:** _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient (or parent/guardian's) employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse (or parent/guardian's) name: _____ Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Person Responsible for Account:

Self Spouse Parent Other _____

If other than self or if you do not have your insurance card, please complete the next section.

Insurance Information:

Name of insured: _____ Relationship to patient: _____

Date of Birth: _____ Social Security Number: _____

Is this insurance provided to you through your employer? YES NO

Name of Employer: _____ Work Phone: _____

Employer Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Address: _____

Group Number: _____ Certificate Number: _____

Do you have an office visit co-pay? YES NO **Do you have additional insurance?** YES NO

If yes, please provide group number and certificate number: _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to Eye Associates of Northern New England, LLP.

X _____ Date: _____

Signature of patient (or parent/guardian, if minor)