Welcome to New Bremen EyeCare!

1. Patient Information

Last Name:_____ First Name: _____

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

Date of Birth:_____ Email: _____

Home Phone: _____ Cell Phone: _____

□ Student

In case of an emergency, who may we contact?

Name: _____ Relationship:_____

Home Phone: _____Cell Phone: _____

Who is responsible for this account?

□ Myself

□ Other: Name:_____ Relation to Patient: _____

Physician's Name: _____ City: _____

Pharmacy Preference: _____ City: _____

2. Vision Insurance Information

Vision Insurance Name: _____Policyholder Name:_____

Policyholder Date of Birth: _____ Policyholder Employer: _____

SSN or last 4 digits of plan member's SS# _____

3. Medical Insurance Information

Insurance Name: _____Policyholder Name:_____

Policyholder Date of Birth: _____ Policyholder Employer: _____

4. Assignment & Release

I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me , or my dependent (s), for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether not paid by insurance.

- For insurance plans in which we are participating, all co-pays & deductibles are due at the time of service.
  INITIAL_____
- Please be aware that some, and perhaps all services may not be covered and that you are responsible for your bill.
  INITIAL_____

_____

Signature of Patient, Parent, or Guardian, or Personal Representative

_____

Please Print Name of Patient, Parent, or Guardian, or Personal Representative