

**PREMIER EYE CARE & SURGERY, P.C.**

Jason M. Jacobs, M.D.

**PATIENT INFORMATION**

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ SSN #: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ E-Mail address \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name (if applicable) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT OR GUARANTOR INQUIRY**

*(Complete only if someone other than the patient is financially responsible)*

Person or party responsible for payment of patient account: \_\_\_\_\_

Address of responsible party: \_\_\_\_\_

Phone number of responsible party: \_\_\_\_\_ Relationship: \_\_\_\_\_

*(Complete if patient is less than 18 years of age)*

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

ID or Member #: \_\_\_\_\_ ID or Member #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insured Employer: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

PCP: \_\_\_\_\_

I authorize the release of any medical information necessary to process all claims and payments of medical benefits directly to my physician.

I am aware of the availability of the Notice of Privacy Practices for Premier Eye Care & Surgery, P.C., and the office policies for handling all such information and indicate that I was notified of the copy available in the office.

I understand that providing insurance information does not constitute payment from my insurance company. Any charges not paid by my insurance company will be the responsibility of the Patient. I understand that the practice of medicine and surgery is not an exact science, and no guarantee has been made or can be made to me as to the result of my treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_