Patient Name ___________________________________ Date of Birth ____________ Male / Female

Address ____City _______________________

State _________________ Zip ____________ Social Security # ______________________________

Home Phone # (______) _________________ Alternate or Cell Phone # (_____) ________________

Email:______________________________ Employer Name / Phone: ___________ (_____)________

How did you hear about us? PCP – Yellow Pages – Internet – Other: ________________________

Name of mother or father if patient is a minor ____

Lexington Eye Associates is required by Centers for Medicaid and Medicare services to ask the following three questions.

Primary Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native
□ Native Hawaiian/Other Pacific Islander □ Latino □ No Answer

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ No Answer

Preferred Language: □ English □ Spanish □ Other:____

Primary Insurance Information: Name of Plan ____

Primary Policy # ______________________________________ Group # if any__________________

Subscriber of Insurance Plan: ___________________**Date of Birth**: _______________Male/Female

Do you have Vision Coverage? Yes / No

Secondary Insurance Information: Name of Plan ____

Secondary Insurance Policy# ______________________________ Group # if any________________

Subscriber of Secondary Insurance?____

Primary Care Physician: Name: ___________________________ Address_____________________

City ________________________ State _______ Zip ___________ Telephone # (_____) __________

HMO: I have an obligation to furnish Lexington Eye with up-to-date insurance information. If I have joined an HMO, I understand that I must obtain referrals from my PCP, if a referral is needed, prior to my visit and if I choose to be seen without said referral, I am responsible for any charge rejected by my HMO.

OTHER: Office policy is for patient payment when service is rendered unless Lexington Eye has a signed contract with my insurance carrier or other arrangements are made in advance with the office/billing secretary. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance carrier. I directly assign all medical/surgical benefits to Lexington Eye and understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize release of all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL

Signature ____ Date ______________________________