

Semel Vision Care

How did you hear about us? Doctor(name)_____ Web__ Friend __ Other_____

Personal Information:

Name_____ Male___ Female___

Date of birth_____ Age_____ Driver's License_____

Address_____ City_____ State_____ Zip_____

Telephone ()_____ Cell Phone ()_____ E-mail_____

Marital Status: Single___ Married___ Divorced___ Separated___ Widowed___

Employer_____ Occupation_____

Address_____ City_____ Zip_____

Telephone Number_____ Social Security #_____

In case of emergency_____ Relationship_____ Phone_____

Financial Information:

Do You Have Routine Vision Insurance Coverage? Name of Ins _____

(MEDICAL INSURANCE DOES NOT COVER ROUTINE EYE EXAM OR EYEGLASSES)

Cash___ Credit Card___ Medicare___ Medicare & Medical___ Pvt Ins_____

Insurance Co _____ Policy # _____ Group # _____

Insured: Self___ Spouse___ Parent___ Name of Insured _____

AUTHORIZAION AND TREATMENT, AND FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Semel Vision Care physicians and assistants to treat me. Also, by signing below I am authorizing for Semel Vision Care and it's doctors to furnish the above insurance companies all the necessary information which they may request.

It is the policy of Semel Vision care to require payment at the time of services are provided. In the event the patient is in a prepaid plan only the co payment portion is applicable. By signing below I am stating that I understand the policy. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediate carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below.

I hereby irrevocably assign to the doctor all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS, from my insurance companies and Medicare.

X _____
(Patient's or guardian's signature)

_____/_____/_____
(Date Signed)