CHART#_____

DATE:_____ ENTERED BY:_____
FOR OFFICE USE ONLY

PATIENT INFORMATION FORM

(PLEASE BE SURE TO SIGN ALL APPROPRIATE AREAS FOUND ON THE BOTTOM OF THIS PAGE)

PATIENT NAME:_____ SS#_____

ADDRESS:_____ DATE OF BIRTH:_____AGE:_____

CITY:_____ STATE:_____ ZIP CODE:_____

--email address:_____

HOME PHONE:_____ALTERNATE PHONE:_____[ ] MALE [ ] FEMALE

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED RACE_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY/STATE/ZIP_____ WORK #_____

IN CASE OF AN EMERGENCY: NAME:_____ **PHONE #**_____

INSURANCE INFORMATION:

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

SUBSCRIBER:_____ SUBSCRIBER:_____

RELATIONSHIP TO PT:_____ RELATIONSHIP TO PT:_____

DATE OF BIRTH:_____ DATE OF BIRTH:_____

PLEASE INDICATE PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

PHONE #:_____ WORK#:_____

Briggs Ophthalmology & Associates, S.C.

MEDICAL/INSURANCE AUTHORIZATION

I request that payment of authorized Medicare/commercial Insurance Co. benefits be made to me or on my behalf to the above named doctor for any services furnished by that physician. I authorize any medical information about me to be released to my Insurance Company and its agents, information needed to determine these benefits payable for related services.

X_____
SIGNATURE DATE

I request that payment of authorized medigap benefits be made either to me or on my behalf to the doctor named above for any services furnished to me by that physician. I authorize any holder of medical information about me to release my Medigap company any information needed to determine these benefits or the benefits payable for related services.

X_____
SIGNATURE DATE

I understand that I will take full responsibility for any unpaid balances.

X_____
SIGNATURE