DESERT EYE AND LASER HAL LE, MD

PATIENT INFORMATION PLEASE FILL OUT COMPLETELY

DATE:_____ DATE OF BIRTH_____-_____-_____AGE_____

PATIENT DR/MR/MRS/MS SOCIAL SECURITY NUMBER_____-_____-_____

WHAT IS YOUR MAJOR VISION COMPLAINT_____

HOW DID YOU HEAR ABOUT US_____FULL TIME RESIDENT__YES__NO

_____ _____ _____

LAST NAME FIRST NAME M.I

_____ _____ _____ _____

MAILING ADDRESS CITY STATE ZIP CODE

_____ _____ _____ _____

ALTERNATE ADDRESS CITY STATE ZIP CODE

(____)_____(_____)_____ (____)_____

HOME PHONE NUMBER WORK PHONE NUMBER CELL NUMBER

EMAIL_____

_____ _____

EMPLOYER OCCUPATION

_____ _____ (_____)_____

PERSON TO CONTACT IN EMERGENCY RELATIONSHIP PHONE NUMBER

PRIMARY INSURANCE_____

INSURED NAME_____ID#/ MEMBER NUMBER_____

INSURED DATE OF BIRTH_____GROUP#/ PLAN#_____

INSURED EMPLOYER_____PTS RELATION TO INSURED SELF/SPOUSE/CHILD

SECONDARY INSURANCE_____

INSURED NAME_____ID#/ MEMBER NUMBER_____

INSURED DATE OF BIRTH_____GROUP#/ PLAN#_____

INSURED EMPLOYER_____PTS RELATION TO INSURED:SELF/SPOUSE/CHILD

I request that payment of authorized Medicare or insurance carrier benefits be made to Desert Eye and Laser on my behalf for any services furnished to me by Desert Eye and laser. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to be determine these benefits or the benefits payable for related services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FEES OF ALL SERVICES RENDERED.

_____ _____

Beneficiary Signature or Authorized Party Date