

# BLUE RIDGE EYE CENTER, P.A.

530 BY-PASS 123 - SENECA, SC 29678

PH (864) 985-1110 - FAX (864)985-1410

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Employer/School \_\_\_\_\_ Phone# \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone# \_\_\_\_\_

Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_ Phone# \_\_\_\_\_

### WHO IS RESPONSIBLE FOR BILL:

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Phone# \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Other \_\_\_\_\_ ID# \_\_\_\_\_

I request that payment of authorized Medicare or other insurance benefits be made to me or on my behalf to Blue Ridge Eye Center, P.A. for any services furnished to me by that physician. Certain procedures (for example: contact lens, refractions, cosmetic surgery, refractive surgery and glasses) may not be covered by Medicare and/or other insurance. I understand these charges as well as deductibles and co-payments will be my responsibility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and authorize any holder of medical information needed to determine these benefits payable for related services. I authorize Blue Ridge Eye Center, P.A. to transmit records electronically when necessary. If any records are received by another party in error, I absolve Blue Ridge Eye Center, P.A. of any liability relating to the transmission of such records.

Signature \_\_\_\_\_

Please sign below giving permission to examine and treat you

Signature \_\_\_\_\_