FOUR CORNERS EYE CLINIC

Patient Information

Last Name:________________________ First:____________ Mi:______

Preferred Nickname:____________________ Birthdate:__________ Sex: M / F

Mailing Address:____
Street or PO Box Apt. City State Zip

Home Address:____
Street or PO Box Apt. City State Zip

Home Phone:______________________ Cell Phone:________________

Social Security No:________________

Marital Status: Single Married Separated Divorced Widowed

Employer:________________________ Work Phone:________________

Employer Address:____

Emergency Contact:____________________ Contact's Phone:______________

Primary Physician:____________________ Optometrist:________________

Relationship To Primary Insured: Self Spouse Daughter Son Other

Responsible Party (If Different From Above):______________________________

Social Security No:________________ Birthdate:____________

Home Phone:______________________ Work Phone:________________

Mailing Address:____
Street or PO Box Apt. City State Zip

Home Address:____
Street or PO Box Apt. City State Zip

If Your Insurance Policy Requires A Referral

Before you receive care from Four Corners Eye Clinic, you must contact your Primary Care Physician for a referral. It is your responsibility, not the responsibility of the physician, to be sure a current referral is in place before you receive care. If a proper referral/pre-authorization is not obtained before you receive care, you will be responsible for these charges.

I authorize and request my insurance company to pay Four Corners Eye Clinic all medical and/or surgical benefits due me under the provisions of my policy. I also authorize the release of medical information requested by my insurance company to process this claim. I understand and accept that I am ultimately responsible for all expenses incurred for services provided regardless of my insurance status. Any collection costs, attorney fees, court costs, or service fees incurred to collect on my account will be my responsibility. A $5.00 per month statement fee will be assessed on all accounts over 30 days past due.

Signature:______________________________ Date:____________

Four Corners Eye Clinic Representative:________________