Patient Information
(Please print)

Date _____ **Chart** _____

PATIENT INFORMATION

First Name _____ **MI** _____ **Last Name** _____

Email _____ **Cell #** _____ **Birthdate** _____ **Age** _____

Social Security # _____ **Address** _____ **City** _____ **State** ____

Zip Code _____ **Day Phone #** _____ **Sex** ____ **Language** _____ **Race** _____

Ethnicity _____ **Employer** _____ **Work #** _____ **Martial Status** _____

If Married Spouse's Name _____ **Spouse's Phone #** _____

Referred by (circle one) **Family** **Friend** **Doctor** _____ **Other** _____

EMERGENCY CONTACT

Name _____ **Work #** _____ **Cell #** _____

INSURANCE INFORMATION

Primary _____ **Group #** _____ **ID #** _____

Name of Insured _____ **DOB** _____

Secondary _____ **Group #** _____ **ID #** _____

Name of Insured _____ **DOB** _____

Vision _____ **Group #** _____ **ID #** _____

Name of Insured _____ **DOB** _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR TREATMENT:

I authorize Fogg Remington EyeCare to treat the patient above, authorize the release of any medical information necessary to process this claim and request payment of benefits to Fogg Remington EyeCare.

Date: _____ Signature: _____

MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare and or Medicare Replacement benefits be made on my behalf to Fogg Remington EyeCare for any service furnished to me by the physicians.

Date: _____ Signature: _____