EYE & COSMETIC SURGERY, LLC.

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Henderson, NV 89012
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Please fill this form out and bring it with you the day of your visit.

PATIENT

Name *(Last, First, Initial)*: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home Phone: _____ Work Phone: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower
Birthdate: _____ Social Security Number: _____
Emergency Contact *(Not in your household)*: _____ Phone: _____
How did you hear about us? _____

INSURANCE INFORMATION

INSURED OR PERSON RESPONSIBLE FOR THE BILL:
Name *(Last, First, Initial)*: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home Phone: _____ Work Phone: _____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other *(Specify)* _____
Birthdate: _____ Social Security Number: _____

EMPLOYER INFORMATION:
Employer's Name: _____ Occupation: _____
Employer's Address: _____ Employer's Phone: _____
City: _____ State: _____ Zipcode: _____
Please check one of the primary insurance classifications:
☐ Medicare ☐ Medicare Managed Care ☐ HMO/Managed Care
☐ Champus ☐ Medicare Assistance ☐ Worker's Compensation
☐ Commercial ☐ Auto ☐ Self - Pay
Is your visit is due to an auto or personal injury related accident? ☐ Yes ☐ No

INSURANCE SUBSCRIBER INFORMATION: *(Person who maintains insurance coverage)*
Subscriber Name: _____
Policy/Recipient Number: _____
Group Number: _____ Eligibility Date: _____
If not eligible, date that you made application: _____
Do you have secondary insurance coverage? ☐ Yes ☐ No ☐ Not Sure
If yes, name of insurance company: _____

AUTHORIZATION

AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND PAY INSURANCE BENEFITS:
I hereby authorize Eye & Cosmetic Surgery, LLC. to release information required to process my health care claims and also the payment for Medicare, Medigap or any other insurance benefits be made payable to Eye & Cosmetic Surgery, LLC. on my behalf for any services furnished me by the physician or suppliers of this office. It is further understood that I am financially responsible to Eye & Cosmetic Surgery, LLC. for the annual Medicare deductible, Managed Care Co-Payments, and charges that are not covered under an insurance plan.
I fully understand all of the above information.

Patient Signature: _____ Date: _____

If patient information is for a minor child (age 18 and under), parent or guardian must sign below.

Parent Signature: _____ Date: _____