MOLLEGA EYE CARE AND OPTIQUE'

PLEASE FILL OUT ALL INFORMATION IF USING INSURANCE OR YOU WILL BE BILLED AS A PRIVATE PAY PATIENT

Today's Date:	Preferred Pharmacy:

PATIENT INFORMATION

Last: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single/ Married/ Divorced/ Separated/ Widowed

Preferred name:	Race:	Birth date: / /	Sex: ❑ M ❑ F	Social Security Number IF FILING INSURANCE!

Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	Email:
Occupation:	Employer:	Employer phone no.: ( )	

Chose Clinic because/Referred to Clinic by (please check one box): ❑ Doctor _____ ❑ Hospital ❑ Insurance Plan

❑ Family ❑ Friend _____ ❑ Close to home/work ❑ Internet ❑ Other _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card(s) & driver's license to the receptionist upon completion of form)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Subscriber's Name:	Subscriber's S.S. no.	Birth Date:	
Subscriber's Address:	City:	State:	Zip Code:

Vision Insurance:	Subscriber's name:	Group no.:	Policy no.:
Primary Medical Insurance:	Subscriber's name:	Group no.:	Policy no.:
Secondary Medical Insurance:	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Self-Pay Agreement (If no insurance or out of network):
I agree to pay for medical services rendered at Mollega Eye Care & Optique'. I understand that there are payment plans available upon request.

_____ _____

Patient/Guardian signature *Date*

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mollega Eye Care and Optique' to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

ATTENTION MEDICARE, TRICARE, CIGNA, & BCBS PATIENTS:The refractive portion of the exam is an additional $39.00 fee due on exam.