MOLLEGA EYE CARE & OPTIQUE’

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

PLEASE GIVE YOUR INSURANCE CARD(S) AND PROOF OF IDENTIFICATION TO THE RECEPTIONIST UPON COMPLETION OF FORM OR YOU WILL BE BILLED AS A PRIVATE PAY PATIENT

PATIENT INFORMATION

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

Nick Name:	Race:	Email:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell Phone #: ( )	Home Phone #: ( )

City:	State:	ZIP Code:	Social Security # Mandatory to File Insurance:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to Clinic by (please check box): ❑ Dr. ______ ❑ Insurance Plan ❑ Hospital

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

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD(S) AND PHOTO ID 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 Social Security #:	Subscriber’s Birth date: / /

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

Vision Insurance:	Group #:	Member ID:
Primary Medical Insurance:	Group #:	Member ID:
Secondary Medical Insurance:	Group #:	Member ID:

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 & Optique’ or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Self-Pay Agreement (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*