

**Inland Vision Care - PATIENT INFORMATION:**

Mr. / Mrs. / Ms. / Miss / Dr. or Military Rank \_\_\_\_\_ Branch of Service: USAF / USMC / USA / USN

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ email: \_\_\_\_\_

**FIRST MI LAST**

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: S M D W Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Who referred you to this office?** \_\_\_\_\_ **Who is your regular Medical Doctor?** \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Patient/Guardian **Driver's License # / State:** \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Occupation: \_\_\_\_\_

Spouse Employed By: \_\_\_\_\_ Spouse Work Phone: \_\_\_\_\_

Who can we contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Who is responsible for payment? \_\_\_\_\_

Do we see any of your family members? \_\_\_\_\_ Name(s) \_\_\_\_\_

**List below, all the people to whom we may release information about you, and their relationship to you:**

\_\_\_\_\_

**INSURANCE INFO:**

**Primary Insurance:** \_\_\_\_\_ I.D.# \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ I.D.# \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I, the undersigned, have insurance coverage with the above named insurance(s) and assign directly to Dr. Pabalan all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all reasonable costs of collection should my account become delinquent. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, paper or electronic.

\_\_\_\_\_ DATE \_\_\_\_\_

Signature of Insured/Guardian

**MEDICARE AUTHORIZATION:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Pabalan for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_ DATE \_\_\_\_\_

Beneficiary Signature