MORRISTOWN EYE
CONSULTANTS

PATIENT'S NAME _____

PARENT/SPOUSE_____

HOME ADDRESS _____

CITY / STATE / ZIP_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE _____ EMAIL_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

Would you like to receive text or email reminders (Circle One): Yes or No

Primary Care Physician_____ Who referred you today_____

Pharmacy Name & Town_____

INSURANCE POLICY HOLDER (IF NOT THE PATIENT)_____

INSURED'S DATE OF BIRTH_____ SSN_____

RELATIONSHIP TO PATIENT_____

BILLING – THIS FACILITY WILL GLADLY BILL YOUR IN NETWORK INSURANCE COMPANY ON YOUR BEHALF AS LONG AS YOU PROVIDE US WITH CURRENT COPIES OF YOUR INSURANCE CARDS.

I authorize payment of medical benefits to Morristown Eye Consultants or the names provided for professional services rendered. I understand that I am financially responsible for all office charges, including the balance remaining after any insurance payments. I authorize the release of any medical information necessary to process all claims. **I understand that Medicare considers refractions not medically necessary and therefore is not covered. I am responsible for payment for this service.**

SIGNATURE_____ TODAY'S DATE_____