FRANCIS EYE CENTER

FOR INTERNAL USE ONLY

EMRN: _____

PATIENT INFORMATION

Name (Last First M.I.)		**Employment Status** ☐ Employed - FT ☐ Employed - PT ☐ Retired ☐ Student	
Address		**Employer**	
City, State, Zip		**Address**	
Home Phone Number	**Social Security Number**	**City, State, Zip**	**Phone Number** (Incl. Ext.)
Date of Birth	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Nickname	**Email Address**		
Emergency Contact		Relationship	Phone Number

RESPONSIBLE PARTY INFORMATION

Name (Last First M.I.)	Phone Number
Address	Social Security Number
City, State, Zip	Relationship to Patient

PRIMARY INSURANCE

Name	**Group #**	Subscriber Name	
Address	**Policy #**	Relationship to Patient	
City, State, Zip	**Primary Care Provider**	Date of Birth	**Gender** ☐ Male ☐ Female
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	**Employer**	Employer Phone	

SECONDARY INSURANCE

Name	**Group #**	Subscriber Name	
Address	**Policy #**	Relationship to Patient	
City, State, Zip	**Primary Care Provider**	Date of Birth	**Gender** ☐ Male ☐ Female
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	**Employer**	Employer Phone	

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Patient Name: _____ EMRN: _____

TERTIARY INSURANCE			
Name	**Group #**	Subscriber Name	
Address	**Policy #**	Relationship to Patient	
City, State, Zip	**Primary Care Provider**	Date of Birth	**Gender** ☐ Male ☐ Female
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	**Employer**	Employer Phone	

How did you hear about us?	**Referred by:**

I certify that the information given by me as documented above is correct. I also certify that I have been given Francis Eye Center, LLC's Financial Policy and that copies of the Financial Policy has been made available to me upon request.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Signature _____ Date _____

Relationship to Patient _____