Newport Eye Physicians

Patient Information

Name (Last, First): _____MI: _____

Phone (Home):_____ (Cell): _____ (Work/Business): _____

Address: _____ City: _____ State: _____ Zip: _____

Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ E-mail: _____

Male: ☐ Female: ☐ D.O.B. _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Responsible Party & Primary Physician Information

Responsible Party: Self ☐ (check if same as above) _____ D.O.B. _____

Relationship to Patient: Self: ☐ Spouse: ☐ Other: _____ SSN: _____

Phone (Home):_____ (Cell): _____ (Work/Business): _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Primary Physician: _____Phone:_____

Emergency Contact

Name of person not living with you: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Referral Source

How did you hear about us?
Other Doctor: _____ Friend/Relative: _____ Website: _____
Insurance Co: _____ Mail: _____Other (please specify): _____

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE TREATED AS CONFIDENTIAL AND IN ACCORDANCE WITH STANDARD MEDICAL GUIDELINES.

I HEREBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO *NEWPORT EYE PHYSICIANS*, AND ANY ASSISTING PHYSICIANS, FOR SERVICES RENDERRED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTIONS, AND REASONABLE ATTORNEY'S FEES. I HEREBY AUTHORIZE *NEWPORT EYE PHYSICIANS* TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS, AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Patient's Name: _____

Patient's Signature: _____ Date: _____