Cape Fear Eye Associates PA

1726 Metromedical Drive
Fayetteville, NC 28304-3861
(910) 484-2284

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I hereby assign all benefits paid by my health insurance plan(s) for services I receive, to be payable to the service provider, Cape Fear Eye Associates, PA. I authorize that any information needed to determine these benefits may be released to the Health Care Financing Administration and its agents.This document will remain in effect until revoked by me in writing, and photocopies will be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance, and that any deductible, co-insurance, or other amount not covered by my insurance must be paid at the time of service.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____