CAPE FEAR EYE associates, p.a.

Patient Information

Patient Name (Last, First, Middle)		Patient SSN#	Birthdate	Language	Sex
Patient Address		Billing Address (if different)			
CITY, STATE, ZIP	Patient Phone #	CITY, STATE, ZIP	Phone #		
Primary Care Physician	Referring Physician	Email Address			
Patient Employer		EMERGENCY CONTACT AND RELATIONSHIP			
Patient Occupation		EMERGENCY CONTACT PHONE #			
Diabetes Doctor		Patient Race	Patient Ethnicity		

How did you hear about us? _____

Policyholder for Primary Insurance (If different than above)

NAME (Last, First, Middle)	SSN#	Birthdate
ADDRESS	Employer / Occupation	
CITY, STATE, ZIP	CITY, STATE	
PHONE #	RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

Name of Insurance Company	Policy Number	Group Number	Effective Date

SECONDARY INSURANCE (If applicable)

Name of Insurance Company	Policy Number	Group Number	Effective 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