Mr. Mrs. Miss Ms. NAME (Last, First, MI):			
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	
Address:			
City:	State:	Zip:	
Sex: M F	Marital Status: Married	Single	Divorced Widowed
Social Security Number:	**Date of Birth:**		
Occupation	Preferred language	Race	Ethnicity
Patient Employer:	Address:		
e-mail address:			
Primary Care Physician:	Phone: ( )		
Referring Physician:	Phone: ( )		

Patient's Spouse / or Parent:	Work Phone: ( )
Spouse's or Parent's Employer:	Address:
City:	State: Zip:
Spouse's or Parent's Social Security #	Spouse or Parent: Date of Birth:

ALTERNATE CONTACT (other than your home phone):	
Name:	Phone: ( )

PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:
POLICY #:	POLICY #:

NAME OF VISION PLAN:

My health information may be shared with: (i.e. Family Member)

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits.

I acknowledge receipt of Eye Physicians of Sussex County's Notice of Privacy Practices.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Eye Physicians of Sussex County and/or Ambulatory Surgery Center for all assigned claims. I request that payment of authorized insurance/Medicare benefits not assigned be made either to me or on my behalf to Eye Physicians of Sussex County and/or Ambulatory Surgery Center for any services furnished me by that supplier.

I will be financially responsible for non-covered services, deductibles, co-pays and co-insurance.

There is a $25.00 fee for returned checks.

I am in full agreement with this financial policy.

SIGNATURE	DATE: