Referring Physician:	Full Name:				Date of Birth:		
Social Security Number: Ethnicity: Race: Preferred Language: Cell Phone: Home Phone: Work Phone: Email Address: Occupation: Marital Status: Married Single Divorced Widowed Patient's Spouse/Parent: Alternate Contact Person: Primary Care Physician: Optometrist: Do you wear Prescription Glasses? Yes No Primary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth: Sex: M F Preferred Language: Work Phone: Work Phone: Doyok Phone: Doyouwear Prescription Glasses? Yes No Secondary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth:	Street Address:						
Ethnicity: Race: Preferred Language: Cell Phone: Home Phone: Work Phone: Email Address: Occupation: Employer: Marital Status: Married Single Divorced Widowed Patient's Spouse/Parent: Spouse/Parent Date of Birth: Alternate Contact Person: Alternate Contact Phone: Primary Care Physician: Do you wear Prescription Glasses? Yes No Physician: Optometrist: Do you wear Contact Lenses? Yes No Physician: Policy Number: Primary Insurance: Secondary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth:	City, State, Zip Code:						
Cell Phone: Home Phone: Work Phone: Email Address: Occupation: Employer: Marital Status: Married Single Divorced Widowed Patient's Spouse/Parent: Spouse/Parent Date of Birth: Alternate Contact Person: Alternate Contact Phone: Primary Care Physician: Do you wear Prescription Glasses? Yes No Referring Physician: Optometrist: Do you wear Contact Lenses? Yes No Primary Insurance: Secondary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:	Social Security Number:				Sex: M F		
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Referring Physician: Optometrist: Do you wear Prescription Glasses? Yes No Do you wear Contact Lenses? Yes No Primary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:				<u> </u>			
Referring Physician: Optometrist: Do you wear Contact Lenses? Yes Note that the primary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:	Primary Care Physician:			Do	you wear Pre	escription Glasses? Yes No	
Primary Insurance: Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:	Referring Physician:				•	·	
Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:	Optometrist:				Do you wear Contact Lenses? Yes No		
Policy Number: Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:							
Subscriber Name: Subscriber Date of Birth: Subscriber Date of Birth:	Primary Insurance:				Secondary Insurance:		
Subscriber Date of Birth: Subscriber Date of Birth:	Policy Number:						
	Subscriber Name:				Subscriber Name:		
Vision Plan: VSP Eyemed Other: Vision Policy Number:	Subscriber Date of Birth:			Su	bscriber Date	of Birth:	
Vision Plan: VSP Eyemed Other: Vision Policy Number:				<u> </u>			
	Vision Plan: VSP Eyer	med	Other:	Vis	ion Policy Nu	mber:	
My health information may be shared with: (Such as family member or caretaker)		, be sha	ared with:				
Court as running member of caretaker)	(Sach as family member of caletaker)						

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:	Date:
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