Full Name:			**Date of Birth:**
Street Address:			
City, State, Zip Code:			
Social Security Number:		Sex: M F	
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
Referring Physician:	
Optometrist:	Do you wear Contact Lenses? Yes No

Primary Insurance:	**Secondary Insurance:**
Policy Number:	Policy Number:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

Vision Plan: VSP Eyemed Other:	Vision Policy Number:

My health information may be shared with:
(Such as family member or caretaker)

I authorize any of my medical information to be released 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:**