NEW PATIENT INFORMATION

Personal Information (Please Print)

Name:_____**SS# (last 4)**_____**DOB**_____**Age**___**M /F**

Last First MI

Address:_____

Street City State Zip

Phone: Home:_____**Work**_____**Cell**_____

Is it ok to send text messages? Yes or No **Email**_____

Marital Status (please check one): Single_____**Married**_____**Widowed**_____**Divorced**_____

Occupation:_____**Employer:**_____**Address:**_____

Referring Physician: Name:_____**Phone:**_____

Last First

Primary Care Physician: Name:_____**Phone:**_____

Last First

	Primary Insurance	Secondary Insurance	Vision Insurance
Insurance Name:			
Insurance ID or SS#:			
Insurance Group#			

PHARMACY NAME:_____**Address/Street**_____**City**_____**Zip**_____

Responsible Insured:

Name:_____**SS#(last 4):**_____**DOB:**_____ **Relationship:**_____

Last First

Financial Assignment and Agreement

Payment is expected at the time services are rendered, including insurance co-payments. Please note that for your convenience, we will bill your insurance company. **If, for any reason, the insurance does not pay what is estimated, or delays payment more than sixty (60) days, the balance will become the patient's responsibility**. We will work with you to get your deserved benefits, but the patient and/or guardian is responsible for payment to this office. Accounts older than 90 days are subject to collection fees.

I acknowledge I have read the Shiloh Eye Care Clinic Privacy Notice. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to Shiloh Eye Care and Thao T. Thach, M.D.

Method of Payment:___Cash___MasterCard___Visa ** WE DO NOT ACCEPT CHECKS ******

Signature:_____Date: _____

NEXT PAGE ------->