

PHYSICIANS EYE CARE CENTER, L.L.C.

Patient Information

PLEASE PRINT (Please use your correct first and last name when calling the office for an appointment, etc.)

PATIENTS FULL NAME (FIRST) (LAST)			MAIDEN NAME		<input type="checkbox"/> Single <input type="checkbox"/> Married	
HOME ADDRESS		CITY	STATE	ZIP	HOME PHONE	
AGE	DATE OF BIRTH	YOUR SOCIAL SECURITY #		OCCUPATION		EMPLOYER
BUSINESS PHONE	BUSINESS ADDRESS			CITY	STATE	ZIP
SPOUSE'S NAME			SPOUSE'S DATE OF BIRTH	EMAIL ADDRESS		

MUST BE COMPLETED!

FINANCIALLY RESPONSIBLE PERSON <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		NAME AND ADDRESS IF DIFFERENT FROM PATIENT	HOME PHONE	WORK PHONE
INSURANCE INFORMATION: Please give card(s) to receptionist				
VISION INSURANCE: Insurance Co. Name _____ Address _____				
MEMBER # _____ Subscriber _____				

PRIMARY/MEDICAL INSURANCE:

BLUE SHIELD	MEDICARE	HMO/PPO/PPN
State: _____	I.D. No: _____	Ins. Co. Name: _____
I.D. No: _____	Effective Date: _____	Address: _____
Group: _____	MEDICAL ASSISTANCE	I.D. No: _____
Code: _____		Group: _____
Subscriber: _____ (Person's Name)	I.D. No: _____	Code: _____
Major Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No	MAC: <input type="checkbox"/> Yes <input type="checkbox"/> No Exp. Date: _____	Subscriber: _____ (Person's Name)
	Were you referred?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Primary care Physician: _____	
OTHER	SECONDARY INSURANCE:	
Ins. Co. name: _____	Ins. Co. name: _____	
Address: _____	Address: _____	
I.D. _____	I.D. _____	
Group: _____	Group: _____	
Code: _____	Code: _____	
Subscriber: _____ (Person's Name)	Subscriber: _____ (Person's Name)	

MERTOD OF PAYMENT: Cash Personal Check VISA Mastercard American Express

I authorize P.E.C.C., L.L.C. to apply for benefits on my behalf for covered services rendered by P.E.C.C., L.L.C., and request that the payments be made directly to P.E.C.C., L.L.C. I authorize the release of any necessary information, including medical information to my insurance company which may help in the processing of my claim. If my insurance company is a private insurance company, I understand that after sixty (60) days if the insurance claim has not been settled, I will be fully responsible for the charges. Payment is expected at the time service is rendered. **THE PATIENT IS ALWAYS RESPONSIBLE FOR PAYMENT.** Over and above the insurance payments according to the insurance coverage. Due to increased billing costs, it will be necessary for P.E.C.C., L.L.C. to implement a service charge of 1% per month (12% per annum) or \$5.00 a month, whichever is greater. A service charge may be added to any balance which is 45 days past due.

I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient or Guarantor's Signature _____

(if minor need) Guarantor's D/O/B _____ S.S # _____

Date _____