Universal Eye Center, PA
Medical, Surgical and Routine Eye Care
310 S. Main St., Rolesville, NC 27571
Phone: (919) 438-3937 Fax: (919) 435-6792

PATIENT NAME____ (Please Circle) Male/Female
Last First Middle Initial

Date of Birth______________Race__________Marital Status (Please circle) S / M / D / W

MAILING ADDRESS____

CITY____________________________________STATE________________ZIP CODE___________

Home Phone #_________________Work/Cell #________________Social Security________________

How did you hear about us?___________________Email address___________________________

Pharmacy_______________________________________Phone #_____________________________

Pharmacy Address:____

Primary Medical Doctor/Office_______________________________Phone #____________________

Referring Doctor____Phone #____________________

Emergency Contact: (Name)____

Relationship to Patient:_______________________________ Phone:___________________________

Is your visit accident related? Y N If yes, date of accident:__________________________________

MEDICAL AND/OR VISION INSURANCE CARD HOLDER'S INFORMATION:

Responsible Party________________________Date of Birth___________SS#___________________

Address___________________________City___________________State________Zip____________

Relationship to Patient:____

Place of Employment (Husband/Father/Self)______________________Phone #_________________

Place of Employment (Wife/Mother/Self)________________________Phone #___________________

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Financial Responsibilities:

The undersigned, in consideration of medical services to be rendered Universal Eye Center, PA to the above named patient does hereby agree to pay Universal Eye Center, PA on demand of said services and incidentals incurred on behalf of such patient. **PLEASE SIGN**____________________________

Authorization for Release of Medical Information:

The hospital and attending physician are authorized to release any medical information required in the processing of application for financial coverage for all services rendered to the patient.
PLEASE SIGN:____

Assignments of Insurance Benefits:

I hereby authorize direct payment of medical benefits to the attending physicians or to whomever he designates. I understand that I am personally responsible to the physician for all charges for services.

***PATIENT SIGNATURE**_______________________________________Date__________________

MEDICARE PATIENTS ONLY

Statement to permit payment of Medicare benefits to provider, physicians and patient:
Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made, authorize any holder of medical information about me to release to the health care financing administration and its agents information needed to determine these benefits or the benefits payable for related services.

***P ATIENT SIGNATURE**_______________________________________Date__________________