MARTEL EYE MEDICAL GROUP

NAME: ____ SEX: M / F
(LAST) (FIRST) (MIDDLE)

ADDRESS: ____
(STREET, PO BOX) (CITY) (STATE) (ZIP)

HOME PHONE: ____________________ WORK PHONE: ____________________

SOCIAL SECURITY #: ____________________ DATE OF BIRTH: ____________________

PARENT/LEGAL GUARDIAN: ____________________ PHONE: ____________________

MARITAL STATUS: ____________________ PHARMACY/STREET NAME: ____________________

RACE/ETHNICITY: ____________________ LANGUAGE SPOKEN: ____________________

EMERGENCY CONTACT: ____________________ PHONE: ____________________

WERE YOU REFERRED BY ANOTHER DOCTOR? Y / N

DOCTOR'S NAME: ____________________ PHONE: ____________________

ADDRESS: ____

NAME OF PRIMARY CARE PHYSICIAN: ____

PHONE: ____________________ ADDRESS: ____

____

DO YOU HAVE INSURANCE? Y / N

PRIMARY INSURANCE: ____

NAME OF INSURED: ____________________ DOB: ____________________

RELATIONSHIP TO PATIENT: ____________________

ID NUMBER: ____________________ GROUP NUMBER: ____________________

INSURED SSN (REQUIRED FOR BILLING PURPOSES): ____________________

PLEASE HAVE THE RECEPTIONIST MAKE A COPY OF YOUR ID AND INSURANCE CARDS

FINANCIAL OBLIGATION AND BENEFITS ASSIGNMENT:
I UNDERSTAND MY RESPONSIBILITY FOR ALL CHARGES INCURRED. UNLESS REQUIRED BY MY INSURANCE POLICY, ALL BILLING IS DONE AS A COURTESY. IF I AM COVERED BY AN ACCEPTABLE INSURANCE, I AUTHORIZE RELEASE OF MEDICAL RECORDS INFORMATION AND I REQUEST MY BENEFITS BE PAID DIRECTLY TO THE DOCTOR(S). IF MY INSURANCE DOES NOT COVER ALL CHARGES, I AGREE TO PAY ANY DIFFERENCES UPON REQUEST. IF MY INSURANCE FAILS TO PAY WITHIN 60 DAYS OF BILLING, I UNDERSTAND THAT I WILL BE REQUIRED TO PAY THE ACCOUNT IN FULL.

____________________ ____________________

PATIENT SIGNATURE DATE GUARDIAN SIGNATURE DATE

Patient Agreement Form

I (the patient/guarantor), ____, do acknowledge that if my insurance plan does not pay for the services provided for that patient (please print the name of the patient), __________________________________, that the Martel Eye Medical Group and/or Dr. James Martel supplied for me within 90 days, I will be financially liable for all charges. I (the patient/guarantor) acknowledge that the Martel Eye Medical Group and/or Dr. James Martel are billing my insurance as a courtesy.

_____________________________________ (Please print your name)

_____________________________________ (Print name of guarantor)

_____________________________________ (Please sign – patient/guarantor)

_____________________________________ (Today's date)

I, (the patient/guarantor), ____ understand that any referral or authorization needed from my insurance company or primary care physician is my responsibility to obtain for today's date of service and future dates of services if we are not a provider for you insurance plan i.e. Kaiser, UCD, Hills, Med Clinic, etc.

_____________________________________ (Please print your name)

_____________________________________ (Print name of guarantor)

_____________________________________ (Please sign – patient/guarantor)

_____________________________________ (Today's date)