GOSSAGE
EYE INSTITUTE
AND OPTICAL

PATIENT HOME INFORMATION

Name, Last/First:
Address:
City:
State/Zip:
Home Phone:
SSN:
Gender: M ☐ F ☐ Age:
Marital Status:
Date of Birth:
Primary Care Physician:
Referring Physician:
How did you learn about us?

RESPONSIBLE PARTY IF NOT PATIENT

Name:
Relationship:
Address:
City:
State/Zip:
Home Phone:
SSN:
Date of Birth:
Employer:
Work Phone:
Email:

PATIENT WORK INFORMATION

Occupation:
Employer:
Work Phone:

INSURANCE CARD INFORMATION

Subscriber:
ID:
Policy/Group:

EMERGENCY CONTACT INFORMATION

Name:
Phone:
Please do not use your home phone

Subscriber:
ID:
Policy/Group:

RELEASE OF INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I, THE UNDERSIGNED, HEREBY AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE MY INFORMATION ACQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED. THE SUBSCRIBER ALSO AUTHORIZES HIS/HER INSURANCE COMPANY(S), AT ITS OPTION TO ISSUE INDEMNITY CHECKS TO THE PROVIDER RENDERING SERVICE.

THE SUBSCRIBER DOES HEREBY ACKNOWLEDGE KNOWING THE PROVISIONS AND COVERAGES OF HIS/HER INSURANCE POLICY(S) AND DOES HEREBY AGREE TO PAY THE GOSSAGE EYE INSTITUTE FOR ANY CHARGES NOT COVERED BY THE SUBSCRIBER'S INSURANCE POLICY(S). THESE CHARGES SHALL INCLUDE BUT ARE NOT LIMITED TO DEDUCTIBLES, COPAYS, WRITTEN PRESCRIPTIONS, REFRACTIONS, SPECIAL TESTING AND ANY OTHER NON-COVERED CHARGES OR SERVICES PROVIDED.

Patient Signature

Date