***Outlook EyeCare, PC***

***Wayne M. Grabowski, MD; Joseph P. Shovlin, MD; Colleen M. Coleman, MD and Margaret M. Ritterbusch, OD***

**Patient Information:**

Last Name:_____First Name:_____Middle Initial:_____

Birth Date:_____/_____/_____Age:_____Social Security#_____-_____-_____

Marital Status: Single / Married / Divorced / Widowed Sex: M F

Home Address: (*Street and House Number, or PO box)*_____

(*City, State, and Zip)*_____

Home Phone: ( ____)_____ Work Phone _(_____)_____

E-Mail_____

Occupation:_____ Employer (w/city):_____

**Medical Information:**

*Please write the name, address, and phone number of your primary care doctor below.Also, please provide the name, address, and phone number of the doctor who referred you to us (if applicable), and the name, location, and phone number of your pharmacy.*

| **Primary Care Doctor:** | **Referring Doctor:** | **Pharmacy:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Insurance Information:**

**Person Responsible for Charges:_____Relationship to Patient_____**

**Primary Insurance:_____** ID#_____Group#_____

Cardholder's Name (If other than yourself):_____

Cardholder's Date of Birth (If other than yourself):_____

Cardholder's S.S.# (If other than yourself):_____

**Secondary Insurance:**_____ ID#_____Group#_____

Cardholder's Name (If other than yourself):_____

Cardholder's Date of Birth (If other than yourself):_____

Cardholder's S.S.#(If other than yourself):_____

**Assignment of Benefits/Release of Information:**

I hereby authorize that any Medicare and/or other insurance benefits for services furnished be paid directly to *Outlook EyeCare, PC*. I also agree to accept full financial responsibility for all non-covered services and to pay outstanding balances upon receipt of the monthly statement.

I authorize the physician to release to the Health Care Financing Administration/Insurance Carrier and/or its agents any information required in the processing of all submitted claims.

I agree that a copy of this signature is valid as the original and may be used to support claim appeals on my behalf to my insurance carrier and/or any other jurisdictional state or federal agency.

Signed:_____Date:_____