

MEDICAL INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE _____

ID # _____ GROUP # _____

ADDRESS _____ GUARANTOR'S NAME _____

PLACE OF EMPLOYMENT _____ PHONE _____

GUARANTOR'S SOCIAL SECURITY # _____ DATE OF BIRTH _____

RELATIONSHIP OF PATIENT TO GUARANTOR _____

SECONDARY INSURANCE

NAME OF INSURANCE _____

ID # _____ GROUP # _____

ADDRESS _____ GUARANTOR'S NAME _____

PLACE OF EMPLOYMENT _____ PHONE _____

GUARANTOR'S SOCIAL SECURITY # _____ DATE OF BIRTH _____

RELATIONSHIP OF PATIENT TO GUARANTOR _____

ADDITIONAL MEDICAL COVERAGE

NAME OF INSURANCE _____

ID # _____ GROUP # _____

ADDRESS _____ GUARANTOR'S NAME _____

PLACE OF EMPLOYMENT _____ PHONE _____

GUARANTOR'S SOCIAL SECURITY # _____ DATE OF BIRTH _____

RELATIONSHIP OF PATIENT TO GUARANTOR _____

WORKMEN'S COMPENSATION

NAME OF COMPANY _____ ADDRESS _____

CONTACT PERSON _____ PHONE _____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/ OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO THE PHYSICIANS OF THE EYE CARE PHYSICIANS & SURGEONS OF NJ. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME OR IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCES. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PATIENT'S SIGNATURE _____ DATE _____