Mid-America Eye Center PA

Patient Information Sheet

Patient Name (Last, First)	
Address	
City, State, Zip	
Social Security Number	
Day Phone Number	( )
Cell Phone Number	( )
Email Address	
Date of Birth (01/01/2000)	
Primary Care Physician	
Emergency Contact	
Emergency Phone	( )
How were you referred to our office?/ Referred by:	
Primary Insurance	
Primary Insured Information	DOB: Gender: Relation:
	Policy No: Group No:
Secondary Insurance	
Secondary Insured Information	DOB: Gender: Relation:
	Policy No: Group No:
Optical Insurance	
Primary Insured Information	DOB: Gender: Relation:
	Policy No: Group No:

I hereby authorize Mid America Eye Center as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Mid America Eye and authorize them to submit claims on my behalf for any bills or services furnished to me during the next 12 month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid for by the undersigned.

_____ _____

Date Signature