NEW PATIENT INFORMATION

Shiloh EYE CARE

Personal Information (Please Print)

Name: _____SS# _____DOB_____M__F__
Last First MI

Address:_____
Street City State Zip

Phone: Home:_____Work_____ Cell_____

Is it ok to send text messages? Yes__ No__ Email_____

Marital Status (please check one): Single_____Married_____Widowed_____Divorced_____

Occupation:_____Employer:_____Address:_____

Referring Physician: Name: _____Phone:_____
Last First

Primary Care Physician: Name:_____Phone:_____
Last First

| | Primary lnsurance | Secondary Insurance | Vision Insurance |
|---|---|---|---|
| Insurance Name: | _____ | _____ | _____ |
| Insurance TD or SS#: | _____ | _____ | _____ |
| Insurance Group# | _____ | _____ | _____ |

PHARMACY NAME:_____Address/Street_____City_____Zip_____

Responsible Insured:

Name: _____SS#:_____DOB:_____ Relationship:_____
Last First

Financial Assignment and Agreement

Payment is expected at the time services arc rendered, including insurance co-payments. Please note that for your convenience, we will bill your insurance company. If, for any reason, the insurance does not pay what is estimated, or delays payment more than sixty (60) days, the balance will become the patient's responsibility. We will work with you to get your deserved benefits, but the patient and/or guardian is responsible for payment to this office. Accounts older than 90 days are subject to collection fees.

**I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to Shiloh Eye Care and Thao T. Thach, M.D.**
**Method of Payment: ___Cash ___MasterCard ___Visa **** <u>WE DO NOT ACCEPT CHECKS</u> ******

**Also, by signing this form, you acknowledge you have read the Shiloh Eye Care Clinic Privacy Notice.**

Signature:_____Date: _____