DELRAY EYE ASSOCIATES
Patient Information

PLEASE PRINT:

1. Patient Name: ____
   Last First Middle
2. Date of Birth: ____________ Age: ___ Sex: _____ Marital Status: ____________
3. Address: ______________________ City: _______________ State: ____ ZIP: _____
4. Home Phone #: _______________ Cell #: ______________________
5. E-Mail Address: ____
6. Social Security #: ______________________ Occupation: ________________
7. Employer: __________________________ Employer's Phone #: ___________
8. Employer's Address: ________________ City: _________ State: ____ ZIP: ____
9. Spouse or Parents Name: __________________________________
10. Employer: __________________________ Employer's Phone #: ___________
11. Employer's Address: ________________ City: _________ State: ____ ZIP: ____
12. Person to contact in case of emergency: _________________ Phone #: _________
13. Referred by: __________________________________ Today's Date: ______

Insurance Information: Are you a member of an HMO? YES NO
(Health Maintenance Organization)

1. Medicare or Primary Insurance______________________ Phone #: ____________
2. Address: ______________________ City: _________ State: _____ ZIP: ______
3. Name of Insured: _______________________ Social Security #: ____________
4. Policy #: __________________Group #: _______________ D.O.B.:__________
5. Secondary Insurance: __________________________ Phone #: ____________
6. Address: ______________________ City: _________ State: ______ ZIP: ______
7. Name of Insured: _______________________ Social Security #: ____________
8. Policy #: __________________ Group #: _____________ D.O.B: ____________

PLEASE PRESENT INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPY

LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release the Health Care Financing Administration and its agencies, any information needed to authorize these benefits or the benefits payable for related services. I request that payment of authorized Medicare insurance benefits be made on my behalf to Dr. Rosenfeld, Dr. Kronish, Dr. Schaffer, Dr. Jewelewicz, Dr. Winnick, Dr. Gonzalez, Dr. Glatzer, Dr. Werner, Dr. Saitowitz and Delray Eye Associates, P.A. for any services furnished me by those physicians. I also agree that any and all balance will be paid by me, and that photocopies of this form be valid. I request that this information also apply to all other insurance. I understand that I am financially responsible for all charges, whether or not paid by the insurance carrier.

Signed: ____ Date: ___________