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: _____