DELRAY EYE ASSOCIATES, P.A.
PATIENT INFORMATION

PLEASE PRINT:

1. Patient Name: _____
   Last First Middle
2. Date of Birth: _____ Marital Status: _____
3. Address: _____ Apt #: _____

   City: _____ State: _____ Zip Code: _____
4. Home Phone Number: _____

   Cellphone #: _____
5. E-Mail Address: _____
6. Last Four digits of Social Security #: _____
7. Person to contact in case of emergency: _____

   Phone #: _____

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

1. Medicare or Primary Insurance: _____
2. Secondary Insurance: _____

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 will 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: _____

**** Please be aware driving may be impaired following DILATION ****