GARDEN STATE EYE CENTER

Patient Information

Name: _____ DOB: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ (Please circle best number to reach you at.)

S.S. #:_____-____-_____ Sex: _____ Marital Status: S M W D

Email Address: _____ Referred By: _____

Primary Physician: _____ Primary Physician Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Policy Number: _____

Name of Policy Holder (if different from the patient): _____

Relationship to Patient: _____ DOB: ____/____/____ S.S. #:_____-____-_____

Secondary Insurance: _____ Policy Number: _____

Name of Policy Holder (if different from the patient): _____

Relationship to Patient: _____ DOB: ____/____/____ S.S. #:_____-____-_____

By my signature, I confirm that all information is accurate and correct.

I will be responsible to inform Garden State Eye Center of any and all changes in my address, phone number(s) and insurance information. Any outstanding balances such as co-insurance, non-covered services or lapse of coverage will be the patient's responsibility. Balances that are outstanding will accrue an interest charge of **1.5%** per month until paid in full. Co-payments and yearly deductibles are **due** at **time of visit**.

I understand that if my insurance requires referrals that it is my responsibility as the patient to obtain that referral and that a referral must be present at the time of visit. If no referral is present at time of visit that appointment will need to be rescheduled due to non-compliance in this matter.

Patient Signature: _____ Date: _____