

Center for Advanced Eye Care / Advanced Eye Surgery Center

3500 US Highway 1
Vero Beach, Florida 32960

Personal Information Form

Please Print

Mr./ Mrs./ Miss/ Ms/ Dr Last Name _____ Date _____ MI _____
First Name _____
Date of Birth _____ Sex _____ Social Security # _____
(this is required by Agency for Healthcare Admin) City _____
Address _____ ST _____ Zip _____
Is this address: ☐ Private residence ☐ Assisted living facility ☐ Skilled nursing facility
Home Ph _____ Work Ph _____ Cell Phone _____
Employer _____ Is visit for work related injury? Y ☐ N ☐
Email Address _____ Occupation _____
Primary Care Physician _____ Phone _____
Referred by _____ ☐ Friend ☐ Relative ☐ Physician ☐ Newspaper ☐ radio

Responsible Party

Last Name _____ First Name _____ MI _____
Address _____ City _____ ST _____ Zip _____
Home Ph _____ Work Ph _____ Employer _____
Date of Birth _____ Sex ☐ male ☐ female Social Security # _____

Insurance Information

Primary Ins _____ Policy # _____ Group # _____
Name of Insured (policy holder) _____ Relationship to insured ☐ self ☐ other
Soc Sec # of Insured _____ Insured's Date of Birth _____
Secondary Ins _____ Policy # _____ Group # _____
Name of Insured (policy holder) _____ Relationship to insured ☐ self ☐ other
Soc Sec # of Insured _____ Insured's Date of Birth _____

Emergency Contact Information:

Name: _____ Relationship: _____
Primary Phone _____ Secondary Phone _____

I agree that The Center for Advanced Eye Care may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Release: I certify that the information I have provided is correct. I authorize the release of medical information to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. Full payment is expected at the time of visit if we do not participate with your insurance. If you are unsure about your private health insurance policy, and whether we are participation providers, it is the patient's responsibility to contact their insurance company prior to arrival for scheduled appointment.

We are firmly committed to your privacy and protection of your information. We use secure measures to protect against the loss, misuse and alteration of data used by us. We do not share, sell, rent or distribute your email and personal information in any way. If you receive an email from us that looks suspicious please contact us. If you wish to unsubscribe, simply reply to our email and request to be removed.

I have read and understand the above information related to insurance billing.

Patient's Signature _____ Date _____