VALLEY EYECARE CENTER MEDICAL ASSOCIATES

CHART #: ` **PATIENT INFORMATION** **PROVIDER:**

LAST NAME:	**FIRST:**	**MIDDLE NAME:**	**EMAIL ADDRESS:**
ADDRESS:	**CITY:**	**ZIP CODE:**	**STATE:**
HOME PHONE #: **CELL PHONE#:** **WORK PHONE #:**	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**	**MARITAL STATUS**: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER
EMERGENCY CONTACT:	**PHONE:**		**RELATIONSHIP:**

PRIMARY CARE PHYSICIAN:

REFERRED BY:

PRIMARY INSURANCE COMPANY: ☐ SAME AS ABOVE

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY INSURED LAST NAME:	**PRIMARY INSURED FIRST NAME:**	**PRIMARY INSURED SSN#:**	**PRIMARY INSURED DOB:**
PRIMARY INS GROUP #	**PRIMARY INS ID #:**	**PRIMARY INS ELIGIBILITY PHONE#:**	

SECONDARY INSURANCE COMPANY NAME: ☐ SAME AS ABOVE

SECONDARY POLICY HOLDER'S LAST NAME:	**SECONDARY POLICY HOLDER'S FIRST NAME:**	**SECONDARY POLICY HOLDER'S SSN#:**	**SECONDARY POLICY HOLDER'S DOB:**
SECONDARY INS GROUP #:	**SECONDARY INS GROUP ID #:**	**SECONDARY INS ELIGIBILITY PHONE #:**	

VISION INSURANCE COMPANY NAME ☐ SAME AS ABOVE

PRIMARY INSURED LAST NAME:	**PRIMARY INSURED FIRST NAME:**	**PRIMARY INSURED SSN#:**	**PRIMARY INSURED DOB:**
PRIMARY INS GROUP #:	**PRIMARY INS ID #:**	**PRIMARY INS ELIGIBILITY PHONE#:**	

I hereby give lifetime authorization for payment of Medicare and all insurance benefits to be made directly to Gagnon Vision Medical Group, Inc.., DBA Valley EyeCare Center, and any assisting physicians, for services rendered. I give this office permission to furnish my insurance company(s) any information it may request, including copies of records. I understand that it is my responsibility to follow the guidelines and to know the coverage and benefits of my medical and vision care insurance plans. If I am a member of a managed care program, it is my responsibility to notify the office that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for any balance due on my account, for services not covered by my insurance, and for all services for which I have not obtained a valid referral. I agree to pay a fee if cancelled or rescheduled appointment is not done within 24 hours or one (1) business day. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_____ Date:_____