LEHMANN EYE CENTER DOCTORS SURGERY CENTER

HOW DID YOU HEAR ABOUT LEHMANN EYE CENTER?

□ Friend or Family □ TV □ Newspaper □ Yellow Pages □ Internet
□ Doctor Referral _____ □ Other _____

Date of Last Eye Exam _____ By Whom _____

Medical Doctor/City _____ Preferred Pharmacy/City _____

PATIENT INFORMATION

Name _____ Single ____ Married ____ Widowed ____
(First) (Middle) (Last)

Address _____ City _____ Zip _____

Home Phone# _____ Cell # _____ Work # _____

Email Address _____

Date of Birth _____ Age _____ Social Security # _____

Occupation/ Employer _____

Spouse or Parent's Name _____ Phone # _____
(First) (Middle) (Last)

Date of Birth _____ Social Security # _____

IN CASE OF EMERGENCY – CONTACT

Name _____ Phone # _____

INSURANCE

□ Medicare □ Medicaid □Commercial Insurance □ Self Pay

The above information is correct to the best of my knowledge. If applicable, I request that Lehmann Eye Center file Medicare/Insurance Claims and that payments of authorized benefits be made on my behalf to Lehmann Eye Center/ Doctors Surgery Center for any services furnished to me by the attending physician. I authorize the release of any medical information necessary to process Medicare and any Insurance Claim. I am aware that any balance not covered by my insurance will be my responsibility.

I authorize Lehmann Eye Center/Doctors Surgery Center to release any information regarding my Medical History, Diagnosis, Care, Treatment, or Progress to the following. We may release all information unless specified to :

(names)_____

Patient Signature _____ Witness _____ Date _____

Please complete and email this form to patients@lehmanneyecenter.com before your first appointment.