

**PATIENT INFORMATION**

FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_  
DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DRIVERS LIC # \_\_\_\_\_  
PHONE # (\_\_\_\_) \_\_\_\_\_ AGE \_\_\_\_\_ M/F \_\_\_\_\_ M S W D \_\_\_\_\_  
CELL # (\_\_\_\_) \_\_\_\_\_ E-MAIL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
REFERRED BY \_\_\_\_\_  
PRIMARY DR \_\_\_\_\_

**INFORMATION**

(PARENT'S IF PATIENT IS A MINOR)

EMPLOYER \_\_\_\_\_  
WORK PHONE # (\_\_\_\_) \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE#(\_\_\_\_) \_\_\_\_\_  
RESPONSIBLE PARTY \_\_\_\_\_  
NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE # (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE # (\_\_\_\_) \_\_\_\_\_ PHONE # (\_\_\_\_) \_\_\_\_\_  
SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER NAME \_\_\_\_\_  
SUBSCRIBER DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SUBSCRIBER DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
ID # \_\_\_\_\_ ID# \_\_\_\_\_  
GROUP # \_\_\_\_\_ GROUP # \_\_\_\_\_

**ADDITIONAL INFORMATION**

FRIEND/RELATIVE (NOT LIVING WITH YOU) \_\_\_\_\_  
PHONE # (\_\_\_\_) \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**AUTHORIZATIONS**

AS A COURTESY, YOUR INSURANCE COMPAINES WILL BE BILLED;  
HOWEVER, PAYMENT IS DUE AT TIME OF SERVICES RENDERED. I UNDERSTAND I  
AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE.

I HEREBY AUTHORIZE THE PHYSICIANS OF GREGORY A. STAINER,  
M.D., F.A.C.S, A PROFESSIONAL MEDICAL CORPORATION/SOUTHWEST EYE CARE  
AND LASER MEDICAL ASSOCIATES TO PERFORM ANY AND ALL FORMS OF TREATMENT,  
MEDICATIONS AND THERAPY, AND TO FURNISH INFORMATION TO INSURANCE  
CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.

I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL  
SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I ALSO REQUEST PAYMENT  
OF GOVERNMENT BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE