

**Groat Eyecare Associates, P.A.**

**PATIENT INFORMATION**

**Name of Patient** \_\_\_\_\_  
First Middle Last

Mailing Address \_\_\_\_\_  
Street/Box Number City State Zip

Telephone \_\_\_\_\_ Cell \_\_\_\_\_ (If no phone, give number/name of friend)

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female  
Mo Day Year

Marital Status (check one)  Married  Single  Widow  Divorced

Race (check One)  Caucasion  African-American  Hispanic Other \_\_\_\_\_

Name of Person Responsible for Bill \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street/Box Number City State Zip

**Patient's Employer** \_\_\_\_\_  
(if child, give responsible party's)

Occupation \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Name of Spouse** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Patient's Medical Doctor** \_\_\_\_\_

**Referred By** \_\_\_\_\_

★ **Payment is required at the time of service. At your request, will assist you in filling your insurance.** ★

**PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST!**

Patient's Social Security Number \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_

If patient is a child, Social Security Number of insured Parent \_\_\_\_\_

Date of Birth of insured Parent \_\_\_\_\_

**ASSIGNMENT: I hereby authorize my insurance benefits to paid directly to Groat Eyecare Associates, P.A., realizing I am responsible to pay non-covered services, deductible, and co-payments; and I hereby authorize the release of pertinent medical information to insurance carriers, including CMS if I have medicare.**

Signed by Patient \_\_\_\_\_ Date \_\_\_\_\_

Signed by Insured \_\_\_\_\_ Date \_\_\_\_\_