



# ATLANTIC EYE

279 THIRD AVENUE, SUITE 204. LONG BRANCH, NJ, 07740 | 732.222.7373  
 2640 RT. 70, BLDG. 7B, SUITE 101. MANASQUAN, NJ 08736 | 732.223.6555  
 100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140  
 180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

## ATLANTIC EYE PHYSICIANS, PA – CONFIDENTIAL PATIENT ENTRY SHEET

**Patient Information:** Acct# \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Male** **Female**

**City, State, Zip:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_\_ **Telephone (Home):** \_\_\_\_\_

**Social Security #:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Telephone (Work):** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone (Cell):** \_\_\_\_\_

## EMPLOYMENT INFORMATION

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

## INSURANCE INFORMATION – PLEASE PRESENT ALL INSURANCE CARDS

**Insurance Company:** \_\_\_\_\_ **ID:** \_\_\_\_\_

**Subscriber:** \_\_\_\_\_ **S.S#:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **DOB:** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

## EMERGENCY CONTACT

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PAYMENT OF PROFESSIONAL FEES

**Full payment / Co-payments are due at the time of service.**

We are a participating facility and accept assignment of Medicare benefits. You are STILL RESPONSIBLE for the Medicare deductible, 20% co-payment and Refraction fee. Medicare lifetime signature on file: "I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Physicians for any services furnished me by the physicians or supplier."

If your insurance company requires a referral prior to service, we cannot provide the service until YOU have secured the referral from your Primary Care Physician. "I have read and understand this document and authorize payment of any insurance benefits for unpaid services to the Atlantic Eye Physicians and understand that I am responsible for any balances or unpaid insurance claims. I authorize the release by Atlantic Eye Physicians of my medical information that is necessary to evaluate and pay my medical insurance claims." *Balances over 90 days will incur a finance charge of 1% per month on the unpaid balance – 12% APR.*

**By signing below, I acknowledge that I have read and understand all of the above information.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Patient Representative's Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_