ATLANTIC EYE

279 THIRD AVENUE, SUITE 204. LONG BRANCH, NJ, 07740 | FAX: (732) 222-7372
2640 RT. 70, BLDG. 7B, SUITE 101. MANASQUAN, NJ 08736 | FAX: (732) 223-3228
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | FAX: (732) 796-7226
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | FAX: (732) 219-9557
CALL CENTER: 732.222.7373

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 and understand that I am responsible for any balances or unpaid insurance claims. I authorize the release by Atlantic Eye 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:** _____