



ATLANTIC EYE

300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373
 1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 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

PATIENT INFORMATION

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: _____