DATE: _____

PLEASE FILL OUT FORM COMPLETELY AND SIGN AT BOTTOM

PATIENT INFORMATION

Patient's Name (First, Middle, Last)

Patient's Address

City, State Zip

Date of Birth Age Sex SS#

Home Phone Work Phone Marital Status

E-mail address:

Pharmacy Name & Address

Phone Number

Are You: Actively Employed Retired

EMPLOYER'S INFORMATION

Employer

Employer's Address (Street)

City, State Zip

Occupation (Indicate if Student)

EMERGENCY CONTACT

Name (First, Middle, Last) Relationship

Address

Home # Cell #

PRIMARY CARE/PEDIATRICIAN INFORMATION

Doctor's Name Office Phone

Address

City, State Zip

FILL IN FOR SPOUSE

Spouse's Name Date of Birth

Employer

Employer's Address

City, State Zip

Is Spouse: Actively Employed Retired

INSURANCE

Primary Insurance Effective Date

Name of Policy Holder

Policyholder's Employer

Policy/Certificate Number Group Number

Secondary Insurance Effective Date

Name of Policyholder

Policyholder's Employer

Policy/Certificate Number Group Number

IF PATIENT IS A MINOR

Father's Name (First, Middle, Last)

Employer Employer's Phone

Employer's Address

City, State Zip

Mother's Name (First, Middle, Last)

Employer Employer's Phone

Employer's Address

City, State Zip

DID YOU HAVE AN INJURY?

Is it a work injury or car accident?

If other type of accident where did it happen?

Date of Accident/Description

Name and Address where bill should be sent

Address

City, State Zip

Phone Number

Is there a Claim or Reference Number?

I request that payment of insurance benefits be made to Robert M. Berger, M.D., P.C., William C. Seefeld, M.D., P.C., Steven T. Berger, M.D., P.C., Frank McCabe, M.D., Melvyn Defrin, M.D., John C. Holdsworth, P.C. or Baystate Eye Care Group for any services furnished by that provider. I authorize the same provider to release to the insurance carrier or agent any medical information needed to determine these benefits or benefits for related services.

PATIENT / GUARDIAN SIGNATURE X _____

Revised 3/2009