PATIENT INFORMATION — PLEASE PRINT

LAST NAME	FIRST NAME	MI	PATIENT'S SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH	SEX	MARITAL STATUS
	F M	S M W DIV SEP

STREET ADDRESS	CITY	STATE	ZIP

RACE (Government requested) PLEASE CIRCLE ONE

BLACK OR AFRICAN AMERICAN WHITE HISPANIC AMERICAN INDIAN ASIAN INDIAN

NATIVE ALASKAN NATIVE HAWAIIAN PACIFIC ISLANDER GREEK MULTIRACIAL OTHER

PRIMARY LANGUAGE (Government requested)			
OCCUPATION		EMPLOYER NAME	

PRIMARY CARE PHYSICIAN	DIABETIC OR RHEUMATOLOGY SPECIALIST	YES OR NO

HOME PHONE	CELL PHONE	WORK PHONE	CONTACT PREFERENCE
( )	( )	( )	HOME CELL WORK

E-MAIL ADDRESS

DO YOU WISH TO OPT-IN TO IOWA EYE CENTER NEWSLETTER? ☐ Yes ☐ No

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

INSURANCE INFORMATION
PLEASE PRESENT INSURANCE CARDS AT CHECK-IN

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT)

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT
	F M	SELF SPOUSE PARENT OTHER

HOME ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP	HOME PHONE
				( )

EMPLOYER	WORK PHONE
	( )

Please complete reverse side

INSURANCE AUTHORIZATION

As a courtesy to our patients we will file claims to your insurance company with the information you provide at the time of service. Due to the ever-changing nature of insurance we are unable to guarantee payment by your insurance company. We will be glad to try and help you with your insurance questions but it is ultimately the patient's responsibility to know and follow any policy guidelines and restrictions of your particular policy.

- **I understand that I remain financially responsible for all medical fees incurred for services rendered by Iowa Eye Center and agree to pay, all charges not covered by insurance and any applicable co-payments and/or deductibles.**
- **I authorize the release of any medical or other information necessary to process insurance claims for services rendered by Iowa Eye Center.**
- **I authorize payment of medical and/or vision benefits directly to Iowa Eye Center for services rendered.**

X _____

Patient or Authorized Representative **Date**

If you have Medicare please complete the following:

Are you (or your spouse) currently working?	**Yes**	**No**
Are you receiving benefits under an employer's disability policy?	**Yes**	**No**
Do you have end stage renal disease?	**Yes**	**No**

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient

Name of Beneficiary _____ **Medicare #**_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Iowa Eye Center, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature _____ **Date** _____

Please complete reverse side