DANIEL H. SHARP, M.D. - **STERLING EYE CENTER** - WILLIAM BUCHANAN, M.D.

PATIENT NAME _____ / _____ / _____

(LEGAL FIRST NAME/MIDDLE INITIAL/LAST NAME)

NAME PATIENT GOES BY OTHER THAN LEGAL NAME _____

DATE OF BIRTH _____ / _____ / _____ SEX: M/F MARITAL STATUS: S/M/D/W

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

SOCIAL SECURITY NUMBER _____ / _____ / _____

SPOUSE'S NAME (PARENT OR GUARDIAN NAME IF UNDER 18) _____

ALTERNATE CONTACT NAME _____ RELATIONSHIP _____ PHONE (___) _____

FAMILY DOCTOR _____ PHONE (____) _____

PATIENT EMPLOYER (PARENT OR GUARDIAN IF UNDER 18) _____ OR RETIRED? Y/ N

EMPLOYER ADDRESS _____ PHONE (_____) _____

INSURANCE INFORMATION: PRIMARY INSURANCE _____ POLICY/ID NUMBER _____

INSURED'S NAME _____ DATE OF BIRTH _____ / _____ / _____

INSURED'S RELATIONSHIP TO PATIENT: SPOUSE/PARENT/OTHER _____

INSURED'S EMPLOYER _____

SECONDARY INSURANCE _____ POLICY OR ID NUMBER _____

INSURED'S NAME _____ DATE OF BIRTH _____ / _____ / _____

INSURED'S RELATIONSHIP TO PATIENT: SPOUSE/PARENT/OTHER _____

INSURED'S EMPLOYER _____

WE ARE HAPPY TO BILL YOUR INSURANCE COMPANY FOR YOU. IT IS YOUR RESPONSIBILITY TO GIVE US CORRECT INFORMATION REGARDING YOUR INSURANCE AND TO KNOW THE LIMITS AND EXCLUSIONS OF YOUR POLICY. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT WHETHER MY INSURANCE MAKES A PAYMENT OR NOT. REGARDLESS OF CUSTODY ARRANGEMENTS OR DIVORCE DECREES, THE PERSON BRINGING A DEPENDENT IN FOR SERVICES IS RESPONSIBLE FOR PAYMENT AND IS EXPECTED TO PAY AT THE TIME SERVICE IS RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR MY INSURANCE COMPANY TO PROCESS THIS CLAIM. I AUTHORIZE THE INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO THE PROVIDING PHYSICIAN. I HEREBY CONSENT TO THE TREATMENT FOR MYSELF OR THE ABOVE LISTED PATIENT.

SIGNATURE _____ TODAY'S DATE _____