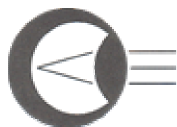

SIGHT EYE CLINIC, P.C. INSURANCE INFORMATION

Primary:___________________________________ Social Security Number: _________ - _________- _________

Policyholder:________________________________ Employer:____

Secondary:__________________________________ Social Security Number: _________ - _________- _________

Policyholder:________________________________ Employer:____

I UNDERSTAND THAT IF MY INSURANCE PLAN REQUIRES AN AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN FOR MY SERVICES PROVIDED BY SIGHT EYE CLINIC, P.C., IT IS MY RESPONSIBILITY TO OBTAIN AN AUTHORIZATION PRIOR TO MY APPOINTMENT.

IF THERE ARE OTHER INSURERS OR PEOPLE RESPONSIBLE FOR THIS PATIENT'S BILL, PLEASE SEE SOMEONE AT THE FRONT DESK FOR MORE INFORMATION.

For MEDICARE recipients only:

Do you live in another state more than six months of each year? Yes___________ No___________

If yes, what state: __________________________________

Are you or your spouse currently employed? Yes___________ No___________

Do you carry insurance through that employer? Yes___________ No___________

VISION INSURANCE

____

Name of Insurance Company Employer

____

Policyholder Name Date of Birth Social Security Number