PHYSICIANS EYE CARE CENTER, L.L.C.

Patient Information

PLEASE PRINT (Please use your correct first and last name when calling the office for an appointment, etc.)

PATIENTS FULL NAME (FIRST) (LAST)			MAIDEN NAME		☐ Single ☐ Married
HOME ADDRESS	CITY		STATE	ZIP	HOME PHONE
AGE DATE OF BIRTH	YOUR SOCIAL SECURITY #		OCCUPATION		EMPLOYER
BUSINESS PHONE	BUSINESS ADDRESS		CITY	STATE	ZIP
SPOUSE'S NAME			SPOUSE'S DATE OF BIRTH	EMAIL ADDRESS	

MUST BE COMPLETED!

FINANCIALLY RESPONSIBLE PERSON ☐ Patient ☐ Spouse ☐ Parent ☐ Other	NAME AND ADDRESS IF DIFFERENT FROM PATIENT	HOME PHONE	WORK PHONE

INSURANCE INFORMATION: Please give card(s) to receptionist

VISION INSURANCE: Insurance Co. Name _____ Address _____

MEMBER # _____ Subscriber _____

PRIMARY/MEDICAL INSURANCE:

BLUE SHIELD	MEDICARE	HMO/PPO/PPN
State: _____	I.D. No: _____	Ins. Co. Name: _____
I.D. No: _____	Effective Date: _____	Address: _____
Group: _____		I.D. No: _____
Code: _____	MEDICAL ASSISTANCE	Group: _____
Subscriber: _____ (Person's Name)	I.D. No: _____	Code: _____
	MAC: ☐ Yes ☐ No Exp. Date:	Subscriber: _____ (Person's Name)
Major Medical: ☐ Yes ☐ No	Were you referred?: ☐ Yes ☐ No	
	Primary care Physician:	

OTHER	SECONDARY INSURANCE:
Ins. Co. name: _____	Ins. Co. name: _____
Address: _____	Address: _____
I.D. _____	I.D. _____
Group: _____	Group: _____
Code: _____	Code: _____
Subscriber: _____ (Person's Name)	Subscriber: _____ (Person's Name)

METHOD OF PAYMENT: ☐ Cash ☐ Personal Check ☐ VISA ☐ Mastercard ☐ American Express

I authorize P.E.C.C., L.L.C. to apply for benefits on my behalf for covered services rendered by P.E.C.C., L.L.C., and request that the payments be made directly to P.E.C.C., L.L.C. I authorize the release of any necessary information, including medical information to my insurance company which may help in the processing of my claim. If my insurance company is a private insurance company, I understand that after sixty (60) days if the insurance claim has not been settled, I will be fully responsible for the charges. Payment is expected at the time service is rendered. THE PATIENT IS ALWAYS RESPONSIBLE FOR PAYMENT. Over and above the insurance payments according to the insurance coverage. Due to increased billing costs, it will be necessary for P.E.C.C., L.L.C. to implement a service charge of 1% per month (12% per annum) or $5.00 a month, whichever is greater. A service charge may be added to any balance which is 45 days past due.

I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient or Guarantor's Signature _____

(if minor need) Guarantor's D/O/B _____ S.S # _____

Date _____