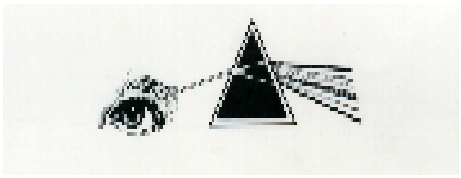
Cochise Eye & Laser



Patient Information Sheet – Please Complete and Return

Last Name		First Name		Middle Initial
Physical Address		City	State	Zip Code
Mailing Address if Different		City	State	Zip Code
Social Security #	Home Phone # ( )	Work Phone # ( )	Birth Date / /	Age
Name of Spouse – Spouse Work#	Marital Status S M D W	Name of Family Doctor		Sex
Emergency Contact NOT Living With You			Phone # of Emergency Contact	

Insurance Names Please List By Order	Policy Holder Name	Relationship To Patient Self Spouse Parent Worker's Comp.
1.		
2.		
3.		

Primary Insurance Holder	Birth Date	Social Security #
Address	Home Phone # ( )	Work Phone # ( )
Secondary Insurance Holder	Birth Date	Social Security #
	Home Phone # ( )	Work Phone # ( )
Parent Information (If applicable)	Parent Birth Date	Parent Social Security #
Address	Home Phone # ( )	Work Phone # ( )

I request that payment under the medical insurance program be made directly to Cochise Eye & Laser on any unpaid bills for services furnished to me by Cochise Eye & Laser. I authorize Cochise Eye & Laser to release any information to insurance carriers needed for this claim. I further permit a copy of this authorization to be used in place of its original.

_____ _____

Patient or Responsible Party Signature Date

If patient is under age 18, parent's name: _____.

I hereby give permission for the doctor/employees of Cochise Eye & Laser to treat my child.

_____ _____

Parent or Legal Guardian Signature Date