Robert R. Palozej OD, LLC

ADVANCED EYECARE

INSURANCE INFORMATION

NAME _____
Last Name First Name Initial

I PREFER TO BE CALLED _____ SS# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

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

PATIENT EMPLOYER / SCHOOL _____ OCCUPATION _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
Last Name First Name Initial

RELATION TO PATIENT _____ BIRTH DATE _____ SS# _____

ADDRESS (if different from patient) _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INURANCE COMPANY _____

ID# _____ GROUP # _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

SUBSCRIBER NAME _____
Last Name First Name Initial

RELATION TO PATIENT _____ BIRTH DATE _____ SS# _____

ADDRESS (if different from patient) _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

SUBSCRIBER EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INURANCE COMPANY _____

ID# _____ GROUP # _____

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

24 hours notice MUST be given if you cannot keep an appointment for any eye exam. If notice is not given a $50.00 fee will be assessed.

Signature _____ Date _____

Payment is due at time of treatment unless prior arrangements have been made.