

Welcome to the Office of Dr. Jack Devore

PATIENT INFORMATION:

Patient's name _____ Sex M F
Date of Birth _____ Age _____ Social Security # _____
Marital Status (circle one) Single Married Divorced Widowed Separated Other
Address: Street _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Day/Work Phone (____) _____
Patient's Employer _____ Occupation _____
Employer's Address _____
Spouse's name _____
Spouse's DOB _____ Spouse's SS# _____
Spouse's Employer _____ Work Phone (____) _____
Family Physician _____ Phone (____) _____
How did you hear about our office? _____

EMERGENCY CONTACT:

PERSON RESPONSIBLE FOR BILL: (if not patient)

Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
_____	_____
Phone (____) _____	Phone (____) _____
	DOB _____ SS# _____

INSURANCE INFORMATION:

Primary _____	Secondary _____
Policy Holder's Name _____	Policy Holder's Name _____
Date of Birth _____	Date of Birth _____
Patient ID # _____	Patient ID # _____
Group # _____	Group # _____

Insurance Authorization and Assignment:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. Jack Devore, O.D. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Date: _____ Signature: _____