Eduardo Besser, M.D.

Account #:_____

Patient Information:

Last Name: _____ **First Name**: _____ **MI**: ___ **Gender**: [_] M [_] F

Address:_____ City:_____

State:_____ Zip:_____

Home #: ( )_____-_____ Work #: ( )_____-_____ Cell #: ( )_____-_____

Social Security #:_____-_____-_____ Date of Birth: ____/____/_____ Age:____

Birth State:_____

Mother's Maiden Name: _____ Marital Status:_____ **Email:** _____

Preferred Language with Clinician: _____

Race: [_] Asian [_] Black or African American [_] Native Hawaiian/ Pacific Islander
[_] Native American /Alaska Native [_] White [_] Other Race

Ethnicity: [_] Hispanic or Latino [_] Not Hispanic or Latino [_] Unknown

Employment Information:

Employer:_____
Occupation:_____

Insurance Information:

Primary Insurance:_____ _____

Policy #:_____ **Group #**:_____ **Phone:** ( )_____-_____

Name of Subscriber:_____ **Date of Birth:**____/____/ _____

Subscriber's SS #:_____-____-_____ Relationship to Insured: [_] Self [_]Spouse [_] Other_____

Secondary Insurance:

_____

Policy #:_____ Group #:_____ Phone: ( )_____-_____

Name of Subscriber:_____ Date of Birth:_____

Subscribers SS #:_____ Relationship to Insured: [_] Self [_] Spouse [_]Other_____

<u>Other Required Information</u>:

Referred by:_____

Address:_____ City:_____

State:___ Zip:_____

Phone: ( )_____-_____ Fax: ( ) _____-_____

Emergency Contact:_____ Relation:_____ Phone:( ) _____-_____

How did you hear about our practice?:_____

By providing your credit card information below, you authorize payment for uncovered services and/or those that are determined to be your responsibility by your health plan. **If you choose not to provide your credit card authorization, be aware that your account will be subject to penalty fees per month for any outstanding balance.** Our practice has implemented stringent security measures to protect your credit card information and will make every attempt to contact you when charging your account.

Credit Card # (MC VISA AMEX) :_____-_____-_____-_____ **Exp. Date:**_____/_____

Signature:_____ **Date:**____/_____/_____

I certify that the information provided is true and accurate. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I authorize payment of medical benefits to Angeles Eye Institute when assignment has been taken. I have read the office financial policy and agree to all terms and conditions. I authorize Angeles Eye Institute to use or disclose any information for treatment, payment, and healthcare operations. I authorize that the physicians and/or employees of Angeles Eye Institute can contact me via all necessary means (phone, email, fax, etc) or leave me a message if they are unable to contact me directly. I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature:_____

Date:_____