

PATIENT  
NAME \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_  
(LAST) (FIRST) (MI)

ADDRESS \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

E-MAIL ADDRESS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
STATUS: MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOW/WIDOWER \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_Phone book \_\_\_Friend/Family \_\_\_A doctor  
\_\_\_Radio \_\_\_TV \_\_\_Internet \_\_\_Newspaper \_\_\_N/A

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
WORK ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY (PARENT OR GUARDIAN IF CHILD) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PRIMARY INSURANCE CARRIER \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_

SECONDARY INSURANCE CARRIER \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

BENEFIT ASSIGNMENT/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance.

\_\_\_\_\_  
Patient or guardian Date

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Weidaw, Kelly and/or Lauf (Maumee Eye Clinic, Inc.) for any services furnished me by that physician. 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 or the benefits payable for related services.

\_\_\_\_\_  
Signature Medicare number Date