

Midwest Eye Physicians

11824 Southwest Highway, Suite 210

Palos Heights, IL 60463

(708) 361-6141 Fax: (708) 361-5327

PLEASE **PRINT** LEGIBLY

Referring Optometrist: _____ Date: _____

Patients Name: Dr. Mr Mrs Ms Miss _____

Address: _____ City: _____ St _____ Zip _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____ Age: _____

Personal Status: **M - S - D - W** (if **Child** – Resp.Party & Relation) _____

Person Resp. for Bill: Self or : _____ Relation to Pt. _____

Your Place of Employment: _____

Address: _____ City _____ St _____ Zip _____

How do you plan to pay for services: **CASH** **CHARGE** **CHECK** **INS.-(Need to copy your card)**

Primary Insurance: _____ Coverage Under: SELF or (IF OTHER)

Name _____ Relation: _____ Date Of Birth: _____

Secondary Insurance: _____ Coverage Under: SELF or (IF OTHER)

Name _____ Relation: _____ Date Of Birth: _____

In Case of Emergency Name & Phone Number (other than your home) Relation: _____

Family Physician & Phone #: _____

PAYMENT IS REQUIRED AT THE TIME OF OFFICE VISIT ONLY IF WE ARE NOT FILING WITH YOUR INSURANCE COMPANY. VISA, MASTERCARD, CHECKS OR CASH. -YOUR INSURANCE COVERAGE MIGHT NOT PAY FOR SOME SERVICES, DUE TO DEDUCTIBLES, CERTAIN POLICY COVERAGE'S, CO-PAYS & ETC. PPO's & HMO's – ALL CO-PAYS NEED TO BE PAID AT TIME OF SERVICE & ALL INS. REFERRALS NEED TO BE GIVEN TO US BEFORE SERVICES, TO VERIFY CORRECT INFORMATION *
REMEMBER SERVICES ARE RENDERED TO YOU NOT YOUR INSURANCE COMPANY, YOU AS THE PATIENT ARE RESPONSIBLE FOR ALL BILLED BALANCES.

I GUARANTEE PAYMENT TO THE UNDERSIGNED PHYSICIAN FOR MEDICAL SERVICES RENDERED. IF PAYMENT IS NOT MADE BY THE INSURANCE COMPANY, I PERSONALLY GUARANTEE PAYMENT TO THE UNDERSIGNED PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature: _____