

# NASHUA EYE ASSOCIATES, P.A.

THANK YOU FOR  
COMPLETING THIS FORM

OFFICE USE ONLY

DATE: \_\_\_\_\_  
ACCT # \_\_\_\_\_

Patient's Last Name	First Name	M.I.	Marital Status S / M / W / D	Date of Birth / /	Sex F / M	Social Security # - -
Permanent Address (Street, City/Town and Zip Code)						
Home Phone Number		Email Address			Primary Care Physician	
If patient under 18 years of age - Parent/Guardian's Name			Soc. Sec. # - -	Date of Birth / /		
Patient/Guarantor's Employer		Occupation (indicate if student)		Business Phone Number		
Employer's Address						
Spouse's Name			Spouse's Date of Birth / /	Spouse's Work Phone Number		
Spouse's Employer			Spouse's Address			
Nearest Friend or Relative Other Than Above		Address			Phone Number	
Has any member of your family been treated by our physician(s) before? (If so, please state name.)						
With whom may we discuss your eye care treatment? (Example: Name of spouse, children, etc.)						
If you are not presently wearing contact lenses, do you have an interest in them? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have an interest in Lasik Surgery to correct nearsightedness, farsightedness or astigmatism? <input type="checkbox"/> YES <input type="checkbox"/> NO  How did you choose Nashua Eye Associates? <input type="checkbox"/> Family/Friend <input type="checkbox"/> Insurance Provider <input type="checkbox"/> Referral by Physician <input type="checkbox"/> Employer <input type="checkbox"/> Location <input type="checkbox"/> Phone Book <input type="checkbox"/> Internet   Other _____  Is there anyone we can thank for referring you to Nashua Eye Associates? Name _____ Address _____						

## INSURANCE INFORMATION:

Person Responsible for Payment	Address	Phone Number		
Insurance Company - Primary	ID Number	Group Number	Effective Date	
Subscriber's Name	Place of Employment	Subscriber's Date of Birth		
Insurance Company - Secondary	ID Number	Group Number	Effective Date	

## WORKER'S COMPENSATION:

Were you injured on the job?	Date of Injury?	Was Employer Notified?	Who was Notified?
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**PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST FOR COPYING**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

\_\_\_\_\_  
SIGNATURE (Patient or Representative)

\_\_\_\_\_  
DATE

Payment is expected at time of appointment. For your convenience, we accept cash, check, MasterCard, VISA and Discover.

# NASHUA EYE ASSOCIATES, P.A.

## Signature on File, Assignment of Benefits

\_\_\_\_\_  
Beneficiary Name (*print*)

\_\_\_\_\_  
Medicare Number

- MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Nashua Eye Associates, P.A. for services furnished me by Nashua Eye Associates, P.A. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Nashua Eye Associates, P.A. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
- MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Nashua Eye Associates, P.A. if possible or otherwise to me.

A copy of this authorization may be used in place of the original.

\_\_\_\_\_  
Beneficiary Signature or Authorized Party

\_\_\_\_\_  
DATE