DAVIDSON EYE ASSOCIATES

James F. Slyman, M.D. **Thomas Hawkins, M.D.**

Title: Mr. Mrs. Ms. Dr. Rev. Sex: Male Female

Patient Name: _____ e-mail _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Social Security Number: _____ Date of Birth: _____

Place of Work: _____ Work Phone: _____

Work Address: _____

Medical Doctor: _____ Referred by: _____

Nearest Friend or Relative who does not live with you: _____

Nearest Friend or Relative Phone Number: _____

PERSON RESPONSIBLE FOR PAYMENT:

Name: _____ Relationship: _____
Address: _____ Phone Number: _____
Social Security Number: _____ Date of Birth: _____
Work Place: _____ Phone Number: _____
Address: _____

INSURANCE COMPANY:

PRIMARY: _____ SECONDARY: _____
Insured's Name: _____ Insured's Name: _____
Social Security Number: _____ Social Security Number: _____
Date of Birth: _____ Date of Birth: _____

WORKERS COMPENSATION

Company Name: _____ Contact Person: _____
Address: _____ Phone Number: _____
Date of Injury: _____

I AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO MY INSURANCE CARRIER, AND TO OTHER PROVIDERS TO WHOM I AM REFERRED. I REQUEST PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO DAVIDSON EYE ASSOCIATES, P.A. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES PROVIDED.

SIGNATURE: _____ DATE: _____

WITNESS: _____ CHART NUMBER: _____