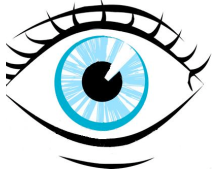

BRIGHTWOOD EYE CENTER
THE OFFICE OF DRS. FRANK AND JUDITH SPAETH

WELCOME FORM

6611 BURLINGTON RD. WHITSETT, NC 27377 336-449-1333 WWW.BRIGHTWOODEYE.COM

DATE ________________

NAME ______________________________
FIRST MIDDLE INITIAL LAST

CIRCLE ONE DR MISS MR MRS MS REV

ADDRESS ______________________________

____

CITY ______________________________

STATE ________________ ZIP ____________

GENDER CIRCLE ONE MALE FEMALE

DATE OF BIRTH ______/______/________

SOCIAL SECURITY # ______-______-______

OCCUPATION ______________________________

EMPLOYER ______________________________

HOME PHONE (_____)________________

CELL PHONE (_____)________________

WORK PHONE (_____)________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

____

PHONE # (_____)________________________

RELATIONSHIP TO PATIENT______________

MEDICAL INSURANCE____________________

ID #______________________________

GROUP # ______________________________

PRIMARY SUBSCRIBER'S FULL NAME:

____

RELATIONSHIP TO PATIENT______________

PRIMARY SUBSCRIBER DOB____/____/______

PRIMARY SUBSCRIBER SOCIAL SECURITY #:

________-_______-________

SECONDARY/SUPPLEMENT/VISION INS:

____

ID #______________________________

GROUP # ______________________________

PRIMARY SUBSCRIBER'S FULL NAME:

____

RELATIONSHIP TO PATIENT______________

PRIMARY SUBSCRIBER DOB____/_____/______

PRIMARY SUBSCRIBER SOCIAL SECURITY #:

________-_______-________

MEDICARE/MEDIGAP AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND, IF APPLICABLE, MEDIGAP BENEFITS, BE MADE EITHER TO ME OR ON MY BEHALF TO DR. SPAETH FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. TO THE EXTENT PERMITTED BY LAW, I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, MY MEDIGAP INSURER, AND THEIR AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

SIGN ______________________________
SIGNATURE OF BENEFICIARY, GUARDIAN OR REPRESENTATIVE

ACCOUNT RESPONSIBILITY

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH THE ABOVE NAMED COMPANY(IES) AND ASSIGN DIRECTLY TO DR. SPAETH ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. DR. SPAETH MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I MAY BE CHARGED A FEE FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE.

SIGN ______________________________
SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR REPRESENTATIVE