ECCARIUS EYE CLINIC

631 St. Anne Street – Suite 103
Rapid City, SD 57701

Whom may we thank for referring you to our office?

_____

_____

PATIENT'S NAME _____
Last **First** **Middle Initial**

PHONE (HOME)_____ **PHONE (WORK)**_____ **PHONE (CELL)**_____

STREET ADDRESS _____ **CITY, STATE, ZIP**_____

E-MAIL ADDRESS _____ **May we contact you via e-mail? YES NO**

SOCIAL SECURITY # _____ **DATE OF BIRTH** _____

SEX: Male Female **NAME OF SPOUSE**

EMPLOYER _____ **OCCUPATION** _____

BUSINESS ADDRESS _____

FAMILY PHYSICIAN _____ **CITY, STATE** _____

Party responsible for payment if other than above _____ **Relationship** _____

Nearest Relative/Friend (not living with you) _____ **Relationship** _____

Address _____ **Phone** _____

NAME OF PARENT (if patient under age 18) _____

INSURANCE INFORMATION:

MEDICARE #: _____ **MEDICAID (T-19)#:** _____

Primary or Medicare Supplement	**Secondary**
Name _____	**Name** _____
Address _____	**Address**_____
_____	_____
Employer Name & Group Policy# _____	**Employer Name & Group Policy#**_____
ID# _____	**ID#**_____
Policy Holder _____	**Policy Holder**_____
Policy Holder's Date of Birth _____	**Policy Holder's Date of Birth** _____

Financial and Medical Record Arrangements

I request that payment of insurance or government benefits be made either to me or on my behalf to Dr. Scott G. Eccarius for any service furnished to me by him. I understand that I am responsible for any amounts not paid by my insurance. I also authorize Dr. Eccarius to release medical records and information about me to determine benefits and procure payment.

PATIENT OR GUARDIAN SIGNATURE _____ **DATE** _____