ADVANCED EYECARE OF NEW YORK
DANIEL LAROCHE MD PC
Glaucoma/ Cataract/ Eye Specialist
Patient Intake Sheet

Welcome to our office

Name:_____Sex____M____F Email address_____

DOB _____ S.S.# _____Marital Status _____

Home Phone Number: _____ Business Phone Number _____

Address: _____

City: _____ State _____ Zip _____

Employer: _____ Phone Number: _____

Referring Source: _____ Phone Number: _____

Who is your medical Dr? _____ Have you seen any other eye doctor? _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of Insured: _____ Relationship to patient: _____

SS # of Insured: _____ DOB of Insured _____

I.D. #: _____ Group #: _____

Secondary Insurance Carrier: _____

SS # of Insured _____ DOB of Insured _____

Name of Insured: _____ Relationship to patient: _____

I.D. #: _____ Group#: _____

Professional services rendered are charged to the patient. All necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay when services are rendered unless other arrangements have been made in advance with our office. If payment is made by check and there are insufficient funds to cover the check amount, you will be responsible for a fee of $30.00. If you schedule an appointment that is not kept, you are responsible for a fee of $50.00. If you do not have vision coverage, you are responsible for a fee of $50.00 for refraction. The charges for any additional medical forms other than an insurance claim form to be completed by the doctor may vary depending on each request and the patient is responsible for paying these fees.

Insurance Authorization/Assignment

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical benefits, including major medical benefits to which I am entitled, to the provider of service. This assignment will remain in effect until revoked by me in writing. A copy of this statement is to be considered as valid as the original.

Medicare patients

I request that payment of authorized Medicare benefits to be made to me or on my behalf to the provider of services furnished tome by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information neededto determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's name _____

Patient's signature _____ Date_____