3515 Trent Road, Suite 9 New Bern, NC. 28562-2220
252-514-2155 Fax: 252-514-0303

PATIENT INFORMATION

NAME (Last, First, Middle)			BIRTHDATE	SEX
PRIMARY ADDRESS				
SS#	HOME PHONE	MOBILE PHONE		RACE
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		

EMERGENCY CONTACT INFO

NAME/ PHONE NO	RELATIONSHIP

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED	GROUP #

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED	GROUP #

I hereby authorize my Medicare or other insurance benefits to be paid to any physician I see at Singleton Vision Center, realizing that I am responsible for paying all non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers.

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SIGNATURE OF PATIENT/GUARDIAN DATE