

Patient Information

Name _____ SS # (Last 4 digits): _____
Address _____ Phone (_____) _____ (home)
City _____ State _____ Zip _____ Phone (_____) _____ (work)
Birth Date _____ Age _____ Gender M F Marital Status _____ Phone (_____) _____ (cell)
Occupation _____ Primary Care Physician _____
Email _____ How were you referred to our office _____
Emergency Contact Person _____ Phone _____ Relation _____

Primary Insurance

Insurance Company _____
Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____
Relation to patient: Self Spouse Parent Other _____
Address (if differs from above) _____ City _____ State _____ Zip _____
Employer _____ Occupation _____

Secondary Insurance

Insurance Company _____
Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____
Relation to patient: Self Spouse Parent Other _____

Vision Insurance

Insurance Company _____
Subscriber's Info: Name _____ Birth Date _____ SS # (Last 4 digits) _____
Relation to patient: Self Spouse Parent Other _____

Assignment and Release

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial. I understand the charges for refraction or contact lens services may not be a covered benefit of my insurance, and I agree to be responsible for these charges.

Signature on File / Assignment of insurance benefit: I hereby assign all medical or Medicare benefits to which I am entitled, private insurance and any other health plans to Ninh H. Tran, M.D. 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. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understood and agreed to the above financial policy for payment of professional fee. The patient is ultimately responsible for all professional fees.

Signature _____ Date _____