URBAN EYE CARE

PATIENT INFORMATION

NAME: _____ SEX: _____ AGE: _____ DATE: _____

PRESENT ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ SINGLE: _____ MARRIED: _____ WIDOWED: _____

RACE: WHITE _____ BLACK _____ AMERICAN INDIAN _____ HISPANIC _____ OTHER _____

SSN: _____ Email Address: _____

WORK INFORMATION

EMPLOYER: _____ BUSINESS PHONE: _____

EMPLOYERS ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ CERTIFICATE NO: _____

POLICY HOLDER - DATE OF BIRTH: _____ SOCIAL SECUITY NO: _____

SECONDARY INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ CERTIFICATE NO: _____

POLICY HOLDER - DATE OF BIRTH: _____ SOCIAL SECUITY NO: _____

IS YOUR INSURANCE AN HMO?	YES _____	NO _____
DOES YOUR INSURANCE REQUIRE A REFERRAL?	YES _____	NO _____
IF YES, DO YOU HAVE A REFERRAL?	YES _____	NO _____

REFERRAL INFORMATION

HOW WERE YOU REFERRED TO DR. ROBERT C. URBAN, JR. M.D.

Optometrist	_____	If so, Name: _____
Other Physician	_____	If so, Name: _____
Friend/Family	_____	If so, Name: _____
Advertisement	_____	If so, Name: _____
Yellow Pages	_____	
Screening	_____	
Other	_____	If so, Name: _____

NAME OF FAMILY PHYSICIAN: _____

Assignment of Benefits

I hereby assign all medical benefits to which 1 am entitled, including Medicare, private insurance, and any other health plan to Robert C Urban, Jr, M.D. (dba: Urban Eye Care). I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Dr. Urban's office to release any and all information necessary to secure payment to my insurance carrier.

Patient Signature (authorization) _____ Date: _____

Printed Name: _____