EYE & COSMETIC SURGERY CENTER OF NEVADA, LLC

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Henderson Office
10870 S. Eastern Ave., Suite 103
Henderson, NV 89052
pnone: (702) 633-5888
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Please fill this form out and bring it with you the day of your visit.

PATIENT

Name *(Last, First, Initial)*: ____________________
Address: ____________________
City: ____________________ State: ________ Zipcode: ____________
Home Phone: ____________________ Work Phone: ____________________
Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced
Birthdate: ____________________ Social Security Number: ____________________
Emergency Contact *(Not in your household)*: ____________________ Phone: ____________
How did you hear about us? ____________________

INSURANCE INFORMATION

INSURED OR PERSON RESPONSIBLE FOR THE BILL:
Name *(Last, First, Initial)*: ____________________
Address: ____________________
City: ____________________ State: ____________ Zipcode: ____________
Home Phone: ____________________ Work Phone: ____________________
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Legal Guardian
☐ Other *(Please Specify)* ____________________
Birthdate: ____________________ Social Security Number: ____________________

EMPLOYER INFORMATION:
Employer's Name: ____________________ Occupation: ____________________
Employer's Address: ____________________ Employer's Phone: ____________________
City: ____________________ State: ____________ Zipcode: ____________

Please check one of the primary insurance classifications:

☐ Medicare ☐ Medicare Managed Care ☐ HMO/Managed Care
☐ Champus ☐ Medicare Assistance ☐ Worker's Compensation
☐ Commercial ☐ Auto ☐ Self - Pay

Is your visit is due to an auto or personal injury related accident? ☐ Yes ☐ No

INSURANCE SUBSCRIBER INFORMATION: *(Person who maintains insurance coverage)*
Subscriber Name: ____________________
Policy/Receipient Number: ____________________
Group Number: ____________________ Eligibility Date: ____________________
If not eligible, date that you made application: ____________________
Do you have secondary insurance coverage? ☐ Yes ☐ No ☐ Not Sure
If yes, name of insurance company: ____________________

AUTHORIZATION

AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND PAY INSURANCE BENEFITS:
I hereby authorize Eye & Cosmetic Surgery Center of Nevada, LLC to release information required to process my health care claims and also the payment for Medicare, Medigap or any other insurance benefits be made payable to Eye & Cosmetic Surgery Center of Nevada, LLC on my behalf for any services furnished me by the physician or suppliers of this office. It is further understood that I am financially responsible to Eye & Cosmetic Surgery Center of Nevada, LLC for the annual Medicare deductible, Managed Care Co-Payments, and charges that are not covered under an insurance plan.
I fully understand all of the above information.

Patient Signature: ____________________ Date: ____________
If patient information is for a minor child (age 18 and under), parent or guardian must sign below.
Parent Signature: ____________________ Date: ____________