Susan M. Berry, M.D.

Patient Information (Please Print)

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: _____

( )Child ( )Unmarried ( )Married ( )Separated ( )Divorced ( )Widowed

Address: _____
Number and Street City State Zip Phone #

Patient Employer: _____

Patient Occupation: _____

Parent's or Spouse's Name: _____

Parent's or Spouse's Employer: _____ Phone #: _____

Patient's Family Physician: _____ Phone #: _____

Who should we contact in the event of an emergency? _____

Address: _____ Phone #: _____

Referred by:( )Doctor: _____ Specialty: _____

Address: _____ Phone #: _____

( )Other: _____
Name Address Phone #

Has any member of your family ever been treated at this office?( )Yes( )NO

Insurance Information

Medicaid #: _____ Medicare #: _____

Other Insurance: _____
Name and Policy Number

Insured's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Social Security Number of Insured: _____

Are you an HMO Patient? ( )Yes ( )No Name of HMO: _____

Are you a PPO Patient? ( )Yes ( )No Name of PPO: _____

( )Workman's Compensation ( ) State Commission for the Blind

Payment for services rendered is due and payable in full at the time of service unless other arrangements have been made in advance.

I request Susan M. Berry, M.D. and staff to perform those tasks necessary for my medical care and to apply any insurance benefits to my account. I realize that any administrative work being performed is on a courtesy basis and that I am responsible for payment of any services not covered by insurance. I hereby authorize Alamo City Eye Physicians, P.A. and Susan M. Berry, M.D. to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Date: _____ Signature: _____
Parent or Guardian if a Minor