GROAT
eyecare associates

First Name:	Last Name:	Birthday:
Gender:	Marital Status:	Social Security #:
Address:	City:	State:
Zip Code:	Email:	Race:
Primary Phone#:	Secondary Phone#:	Ethnicity:
Emergency Contact:	Phone #:	Relation:
Provider:	Family Physician (PCP):	Referring Physician:

Insurance Name:	Address:	Policyholder:	Relation:	Copay:	Policy ID:	Group ID:

Policyholders/Responsible Party

First Name:	Last Name:	Gender:	Birthday:
Social Security #:	Marital Status:		
Address:	City:		
State:	Zip Code:	Email:	
Home #:	Cell #:	Work #:	
Employer Name:	Phone #:		

HIPAA Approved Contacts

First Name:	Last Name:	Phone #:	Relation:
First Name:	Last Name:	Phone #:	Relation:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Groat Eyecare Associates PA, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.
I acknowledge receipt of the practice's notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature: X	Date: X