DAVID J. BENE, M.D.
DISEASES & SURGERY OF THE EYE SPECIALIZING IN GLAUCOMA

PATIENT INFORMATION

Name: _____ Social Security #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number(s): Home: _____ Cell:_____ Work:_____
Date of Birth: _____ Gender: Male Female Marital Status: M S D W
Email: _____

Race: Asian African-American Hispanic Caucasian
Language: English Spanish Other
Ethnicity: Latino Non-Latino

Family Doctor:_____
Primary Pharmacy: _____Location:_____

Emergency Contact Person:_____
Relationship:_____ Phone Number:_____

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I REQUEST THAT PAYMENT OR AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO DAVID J. BENE, M.D. AND AUTHORIZE DR. BENE FOR ANY BILLS FOR SERVICE FURNISHED TO ME BY DR. BENE DURING THE NEXT 12 MONTHS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO DR. BENE FOR ANY BALANCE NOT COVERED BY THIS AUTHORIZATION AND ANY BALANCES NOT PAID WITHIN 120 DAYS WILL BE FORWARDED TO A COLLECTION AGENCY. THIS SIGNATURE IS VALID AS ORIGINAL.

SIGNATURE: _____ DATE:_____
(or Parent, if patient is a minor)