DANIEL H. SHARP, M.D. ***STERLING EYE CENTER***

PATIENT NAME:_____ _____ _____
Legal First Name Middle Initial Last Name

Name patient goes by other than legal name _____

Date of Birth_____/_____/_____ SEX: M F MARITAL STATUS: S M D W
MO DAY YEAR

Mailing Address_____City_____State_____Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Social Security Number _____/_____/_____

Spouse's Name (Parent or Guardian name if under 18)_____

Alternate Contact _____Relationship_____ Phone(_____) _____

Family Doctor_____ Phone (_____)_____

Patient Employer (Parent or Guardian if under 18) _____or Retired? Y N

Employer Address_____ Phone (_____)_____

INSURANCE INFORMATION

Primary Insurance_____ Policy or ID Number_____

Insured's Name_____ Date of Birth_____/_____/_____

Insured's Relationship to Patient: Spouse Parent Other_____

Insured's Employer_____

Secondary Insurance_____ Policy or ID Number_____

Insured's Name_____ Date of Birth_____/_____/_____

Insured's Relationship to Patient: Spouse Parent Other_____

Insured's Employer_____

We are happy to bill your insurance company for you. **It is your responsibility to give us correct information regarding your insurance and to know the limits and exclusions of your policy.**
I understand that I am responsible for payment whether my insurance makes a payment or not. Regardless of custody arrangements or divorce decrees, the person bringing a dependent in for services is responsible for payment and is expected to pay at the time service is rendered.
I authorize the release of any medical information necessary for my insurance company to process this claim.
I authorize the insurance company to send payment directly to the providing physician. I hereby consent to the treatment for myself or the above listed payment.

Signature_____ Today's Date_____