



FALGOUST  
Eye Medical & Surgical  
Donald C. Falgoust, M.D.

# PATIENT INFORMATION SHEET

First Name: \_\_\_\_\_ MI : \_\_\_\_ Maiden Name : \_\_\_\_\_ Last Name \_\_\_\_\_

Phone# (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_ Work# (\_\_\_\_) \_\_\_\_\_ PO Box \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Drivers License: \_\_\_\_\_ M or F

Employer: \_\_\_\_\_

Full Time     Part Time     Student     Retired     Unemployed     Disabled

Marital Status     Married     Single     Divorced     Widowed     Separated

## Primary Insurance Information/Responsible Party

Name of Card Holder: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Employer \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

## Secondary Insurance Information

Name of Card Holder: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Employer \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

## How did you hear about Falgoust Eye Medical & Surgical?

Newspaper     TV     Phone book     Friend     Billboard     Health Fair     Insurance     Word-of-Mouth     Physician Referral

## CONTACT #1 (outside the household)

Name: \_\_\_\_\_ Relation \_\_\_\_\_ PhoneNumber \_\_\_\_\_ Address \_\_\_\_\_

## CONTACT #2 (cannot be a relative)

Name: \_\_\_\_\_ Relation \_\_\_\_\_ PhoneNumber \_\_\_\_\_ Address \_\_\_\_\_

Authorization to treat minor child: \_\_\_\_\_  Mother     Father     Guardian

**I understand it is customary to pay for services when rendered unless other arrangements have been made in advance with our billing manager. In order to keep our charges as low as possible, we expect payment at time of service. If payment is not made at the time of service, you could be assessed interest and delinquent charges.** I authorize use of this signed form for all my insurance submissions. I authorize Falgoust Eye Medical & Surgical to file with my insurance company and I hereby assign, transfer to Falgoust Eye Medical & Surgical all of my rights, title and interest to my medical reimbursement benefit under my insurance policy. I permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges not paid by my insurance company and I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_