The Vitreoretinal Eye Center, P.C.

PATIENT INFORMATION FORM **Avit Gremillion, M.D.**

Date:_____ **REFERRED BY**: _____ Account #:_____

PRIMARY CARE PHYSICIAN:_____

Patient ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed (check one) ☐ Male ☐ Female	Last Name	First Name	Middle/Maiden		Date of Birth
	Street Address	City	State	Zip	Age
	Mailing Address	City	State	Zip	Social Security Number
	Home Phone	Cell Phone			E-Mail Address
	Name of Employer/School				☐ Full Time ☐ Part-Time
Occupation	Employer's Address				Employer Phone Number
In Case of Emergency, Notify		Relationship			Telephone Number
Primary Language Spoken:_____		Ethnicity:			Race:

PHARMACY ADDRESS AND/OR PHONE NO:

_____

Responsible Party ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (check one)	Last Name	First Name	Middle/Maiden	Social Security Number
	Billing Address			Date of Birth
	City, State and Zip Code			Phone – Home
	Employer			Employer Phone Number

PLEASE REMEMBER THAT INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT.
CO-PAYMENT IS DUE AT CHECK-IN.

INSURANCE INFORMATION	Primary Insurance		Secondary Insurance	
	Policy / Contract No.	Group No.	Policy / Contract No.	Group No.
	Insured's ID or Social Security No.	Policy Holder DOB	Insured's ID or Social Security No.	Policy Holder DOB

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed:_____Date_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier.

Signed:_____