New Patient Information

(please print)

NASHVILLE EYE CENTER

Howard H. Rosenblum, MD
Physician and Ophthalmic Surgeon

Last Name_____ **First**_____ **Middle**_____ **Date of Birth**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Occupation_____ **Employer**_____

Home Phone_____ **Work Phone**_____

MALE ☐ **FEMALE** ☐ **Marital Status: M S W D** **SS#**_____

Spouse ☐ **or Parent's** ☐ **Name**_____ **Work Phone** _____

Emergency Relative or Friend_____ **Relationship**_____ **Phone**_____

Personal Physician_____

Who referred you to this office?_____

❖ PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST ❖

Person responsible for payment, if not above:

Name_____ **Relation to patient**_____ **Phone**_____

Address_____

- ***REGARDING INSURANCE*:** **Refraction** (optical or vision exam) is usually **not covered** by medical insurance. I AGREE TO BE RESPONSIBLE for charges not covered by my insurance. I agree to pay late fees and the costs of collection, should my account become delinquent.
- ***BROKEN APPOINTMENTS*:** Please notify the office **24 HOURS IN ADVANCE**, if an appointment needs to be cancelled. Failure to do so may necessitate a charge.

***AUTHORIZATION*:** I request that payment of Medicare or other insurance benefits be made either to me or on my behalf to this office for services furnished to me by Dr. Rosenblum. I authorize any holder of medical information about me to release to Medicare, or other insurer and its agents, information needed to determine these benefits.

SIGNATURE_____ **DATE**_____