New Patient Information

(please print)

NASHVILLE EYE CENTER

Howard H. Rosenblum, MD
Physician and Surgeon

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

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

Occupation_____ **Employer**_____

Phone: Home _____ **Work** _____ **Cell**_____

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_____

READ CAREFULLY:

- ***REGARDING INSURANCE*:** **Refraction** (optical or vision exam) is usually **not covered** by medical insurance. I accept full responsibility for payment of my bill including any deductibles, non-covered services; in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary Care Physician prior to being seen in this office. If seen without a referral, I will be responsible for any services rendered.

- ***BROKEN APPOINTMENTS*:** Please give **24 HOURS NOTICE**, if an appointment needs to be cancelled. Appointments missed without 24 hours notice may necessitate a charge.

***AUTHORIZATION*:** I agree to the above. I request that payment of Medicare or other insurance benefits be made 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**_____