Premier Eye Clinic, P.A.

Q. Jocelyn Ge, M.D., Ph.D.
Eye Physician and Surgeon

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Tel: (386)788-6198 Fax: (386)788-4616

Patient Information

Date_____ Age _____

Last Name_____ First Name_____ MI _____

Address_____

_____

Home Phone _____ Business Phone_____ Cell Phone _____

Date of Birth _____Marital Status: M __ W__ S__ D__ Gender: M__ F__

Social Security #_____ Drivers License # _____

Occupation_____ Employer_____

Employer Address_____

_____

Spouse / Parent Name and Address_____

_____Phone #_____

Nearest Friend or Relative Name not living with you_____

Address_____

_____Phone # _____

Insurance Carrier #1_____

Insurance Carrier #2_____

Family Doctor_____ Referred By _____

I hereby authorize Dr. Q. Jocelyn Ge to furnish / fax information to insurance carriers /Medicare concerning my illness and treatment and I hereby assign to the physician all payments for medical service rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

Date_____Signature_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements are made in advance.