

# **NEGREY-JAHNLE EYE ASSOCIATES**

**John N. Negrey, Jr., M.D.   Richard L. Jahnle, M.D.   Edward J. Mekel, O.D.  
Rocio C. Pasion, O.D.   Freddie J. Davis, O.D.**

## **Welcome To Our Practice**

Please **PRINT** All Information

Pt # \_\_\_\_\_  
For office use only

Mr.   Mrs.   Miss   Dr.

LAST Name of **Patient** \_\_\_\_\_ FIRST Name of **Patient** \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

**Family Physician** \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Patient's** Occupation \_\_\_\_\_ Student \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

If you are a student, name of school/college: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

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### **PERSON RESPONSIBLE FOR PAYMENT (If Patient is a Minor: Parent or Guardian)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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### **VISION INSURANCE INFORMATION: (Please provide us with your card to copy)**

Name of Insurance Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Address to Send Insurance Forms \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Patient's Relationship to the Insured: **Circle one:** Self   Spouse   Child   Other

Subscriber's Employer \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Sex \_\_\_\_\_

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### **MEDICAL INSURANCE INFORMATION: (Please provide us with your card to copy)**

Name of Insurance Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Address to Send Insurance Forms \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Patient's Relationship to the Insured: **Circle one:** Self   Spouse   Child   Other

Subscriber's Employer \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Sex \_\_\_\_\_

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### **SECONDARY MEDICAL INSURANCE INFORMATION: (Please provide us with your card to copy)**

Name of Insurance Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Address to Send Insurance Forms \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Patient's Relationship to the Insured: **Circle one:** Self   Spouse   Child   Other

Subscriber's Employer \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Sex \_\_\_\_\_

**INSURANCE INFORMATION**

**MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized **MEDICARE** benefits be made either to me or on my behalf to **Negrey-Jahnle Eye Associates** for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Patient (or Responsible Party) Signature \_\_\_\_\_  
Date

**PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I hereby authorize and direct payment of my medical benefits to **Negrey-Jahnle Eye Associates** for any services furnished to me by the physicians. I authorize the doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. If my insurance company does not pay the practice within 30 days, I will be responsible for the bill. Payment is due upon receipt of a statement from our office.

\_\_\_\_\_  
Patient( or Responsible Party) Signature \_\_\_\_\_  
Date

**PREFERENCE FOR COMMUNICATION**

We are committed to providing private and efficient communication with you. Please complete the following information as specifically as possible.

Please indicate the preferred method(s) if we need to reach you by phone.

**HOME:** Yes \_\_\_\_\_ No \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you are unavailable, may we leave a detailed message:

With another person? Circle: Yes/No Voice mail or answering machine? Yes/No

**WORK:** Yes \_\_\_\_\_ No \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you are unavailable, may we leave a message:

With another person? Circle: Yes/No Voice mail or answering machine? Yes/No

**CELL:** Yes \_\_\_\_\_ No \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you are unavailable, may we leave a message:

On voice mail? Yes \_\_\_\_\_ No \_\_\_\_\_

**If we leave you a message, which would you prefer?**

Detailed message? \_\_\_\_\_ or Request for you to call our office? \_\_\_\_\_

**IN CASE OF AN EMERGENCY, The Following Person Should Be Notified**

(Family Member or Friend not Living at Your Residence)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR EYECARE NEEDS.**