# PLEASE PRINT

**Name**:_____Date:_____

**Address**:_____
Street City State Zip Code

**Home Phone**:_____**Cell**:_____ **Male** ☐ **Female** ☐

**Birth Date**:_____ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Child**

**SS#**_____ **Preferred Language**: English Spanish Other:_____

**E-Mail Address**: _____
(This is for office use only, so that we can send you copies of your visit and link w/ the patient portal )

**Alternate address:** (if you are a part time resident or if there is a different address to send bills to)

_____
Street City State Zip Code

**Referring Physician/Person**_____

**Spouse's Name**(Parents name if child):_____

**Patient's Employer**:_____**Wk Phone**:_____

**Insurance:** Regular Medicare ☐ Medicare "Advantage" Plan ☐ Private Ins ☐ Your CoPay?_____

***If you are insured through your spouse or parent:***

***Name on insurance card***: _____***Their DOB***:_____

**Person Responsible for payment: Self** ☐ **or** _____

**I request that payment of authorized Medicare and/or Private insurance benefits be made to:**
**THOMAS L. SCHWARTZ, MD / EYE CARE ASSOCIATES OF SARASOTA**
**for any services furnished to me by a physician in this practice. I hereby authorize this office to release any medical and/or personal information needed to determine these benefits payable for services rendered. This provider agrees to accept the assigned charge determined by Medicare. ****REFRACTION* is the optical determination of your best possible vision. It is needed to determine if any optical, medical and/or surgical treatment is necessary. It is an essential part of an eye exam, however it is *NOT COVERED BY MOST INSURANCES- THE FEE FOR REFRACTION IS $50.00***

**My signature below verifies that I understand that I am responsible for paying the insurance(s) deductible(s), co-pay(s) and non- covered service(s) not paid by my insurance(s). This assignment will remain in affect until revoked by me in writing.**

**Signature:**_____**Date:**_____