

**7051 Southpoint Parkway 3<sup>rd</sup> Floor, Jacksonville, FL 32216 (904) 398-2720  
1420 Flagler Avenue, Jacksonville, FL 32207 (904) 425-6060**

- Oculoplastics
- Cosmetic Surgery
- Contact Lenses

- Laser Surgery
- General Ophthalmology
- Prelex

- Refractive Surgery
- LASIK / LASEK
- Restylane / Radiance

Date: \_\_\_\_\_

Sex:      M              F

Name		Date of Birth		Age	Marital Status		
					S	M	W Sep Div
Address							
Apartment No.							
City		State		Zip	SSN		
					--	--	
Home Phone		E-Mail Address			Cell Phone		
Employer				Employer's Address			
City		State		Zip	Business Phone		Ext
Spouse		Date of Birth		SSN			
				--			--
Spouse's Employer				Address			
City		State		Zip	Business Phone		Ext
Emergency Contact		Relationship			Contact Number		
Who is responsible for account?		Relationship		DOB	SSN		
					--		--
Insurance Company		Policy Number			Group Number		
Secondary Insurance		Policy Number			Group Number		
Best time to reach you		Date of last physical examination			Doctor's name		
Reason for last visit							
Referred by					How did you hear about our practice?		
Hobbies and recreation							

**PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE**  
**Please See Reverse**

**Assignment Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_, and assign directly to Dr. Nicolitz and his associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**Medicare Authorization**

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Nicolitz and his associates for any services furnished me by that physician. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of any medical information necessary to pay the claim. If secondary health insurance is indicated above or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charged determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date