Nicolitz Eye Consultants

7051 Southpoint Parkway South 3rd Floor, Jacksonville, FL 32216 (904) 398-2720
1420 Flagler Ave. Jacksonville, FL 32207 (904) 398-2720

Date:_____ Sex: M F

Name Date of Birth		Age	Marital Status S M W Sep Div	
Address Apartment No.				
City Zip	State	SSN -- --		
Home Phone	Cell Phone		Alternate Phone	
Email Address			Can we email you Our Specials? ☐ YES ☐ No	
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		Would you be interested in cosmetic Surgery? □ YES □ No Would you be interested in reducing your dependency on glasses or contacts? □ YES □ No		

PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE

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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 aggress 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