# FILER EYE M.D.

Robert Filer M.D.

## PATIENT INFORMATION

Last Name | First Name | Single Married Divorced Widowed

Date of Birth (mm/dd/yyyy) | (please circle one)

Address | City | State | Zip Code

Home Phone | Work Phone | Social Security #

Employer Name | Occupation

Primary Medical Insurance | Subscriber Name | ID# / Group

Secondary Medical Insurance | Subscriber Name | ID# / Group

Vision Insurance | Subscriber Name

Relationship to Patient | ID#

Name of Primary Care Physician | Name of Optometrist

Person to contact in case of emergency | Phone

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

**I consent to allow Robert Filer, M.D. to leave messages by telephone regarding either appointment confirmation and/or medical information at my home or work.** _____ (initial)

MISSED APPOINTMENTS WITHOUT 48 HOURS NOTICE MAY BE CHARGED. _____ (initial)

**PAYMENT POLICY**

I authorize treatment by Robert Filer, M.D. I authorize release to my insurance carrier any information regarding this illness and/or injury, which is required to process my claim. I hereby assign my insurance benefits directly to Robert Filer, M.D. and I am financially responsible for any charges not covered by my insurance.

Patients are expected to pay at the time of service unless the physician contracts with your insurance plan. Please check with your carrier to see if an authorization is needed. SHOULD YOU NOT HAVE YOUR AUTHORIZATION, YOU WILL BE REQUIRED TO PAY AT THE TIME OF SERVICE.

I have read and understand the above information.

Signature | Date

www.filereyemd.com
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