FAIRFAX EYE ASSOCIATES, INC.

DERTAD MANGUIKIAN, M.D. & ALEX MANGUIKIAN, M.D., Ph.D.

PATIENT INFORMATION

PATIENT NAME:_____ AGE: _____
LAST FIRST MI

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

DATE OF BIRTH: ____ / ____ / _____ SOCIAL SECURITY NO. _____ - _____ - _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MARITAL STATUS: □ Married □ Single □ Divorced □ Widowed GENDER: : □ Male □ Female

PRIMARY CARE PHYSICIAN: _____ EMERGENCY CONTACT IF APPLICABLE
EMAIL : _____ NAME : _____NUMBER:_____

PRIMARY INSURANCE (if applicable)

COMPANY NAME OF PRIMARY INSURANCE: _____

☐ CHECK HERE IF YOU (THE PATIENT) ARE THE PRIMARY POLICY HOLDER AND THEN GO TO THE NEXT SECTION. IF YOUR MEDICAL INSURANCE IS UNDER SOMEONE ELSE'S NAME PLEASE FILL OUT THE INFORMATION BELOW.

Name of Primary Policy Holder: _____

Social Security No. _____ - _____ - _____ Date of Birth: ____ / _____ / _____

Relationship of Patient to Policy Holder: □ WIFE □ HUSBAND □ CHILD □ OTHER

Billing Address: (□ same as patient): _____

SECONDARY INSURANCE (if applicable)

COMPANY NAME OF SECONDARY INSURANCE : _____

☐ CHECK HERE IF YOU (THE PATIENT) ARE THE PRIMARY POLICY HOLDER AND THEN GO TO THE NEXT SECTION. IF YOUR MEDIAL INSURANCE IS UNDER SOMEONE ELSE'S NAME PLEASE FILL OUT THE INFORMATION BELOW.

Name of primary Policy Holder: _____

Social Security No. _____ - _____ - _____ Date of Birth: ____ / _____ / _____

Relationship of Patient to Policy Holder: □ WIFE □ HUSBAND □ CHILD □ OTHER

Billing Address: (□ same as patient) _____

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our office policy is payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Should the insurance carrier fail to pay this account upon demand, and should it become necessary to place this account with an attorney for collection, you are responsible for all costs, including attorney's fees and interest at 1.5% per month (18% per annum).

PATIENT AUTHORIZATION

I hereby authorize Dertad Manguikian, M.D., Alex Manguikian, M.D, Ph.D., or Fairfax Eye Associates to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to the above named provider.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named billing agent and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits payable for related services.

_____ X_____

DATE SIGNATURE OF RESPONSIBLE PARTY