



CLAY EYE PHYSICIANS AND SURGEONS

A PROFESSIONAL ASSOCIATION

2023 Professional Center Drive • Orange Park, FL 32073 • (904) 272-2020
1615 CR 220 • Suite 140 • Orange Park, FL 32073 • (904) 276-2020

OPHTHALMOLOGY – DISEASES AND SURGERY OF THE EYE

C. M. Harris, M.D. • John D. Wilcox Jr., M.D. • John P. Donovan, M.D. • David A. Green, O.D. • Melanie C. Javier, O.D.

PATIENT INFORMATION

Date _____ Referred by _____

Patient Name _____ Male / Female

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Home Phone # _____ Work Phone # _____

Social Security # _____ Driver's License # _____

Primary Care Physician _____

Patients Age ____ <IF THE PATIENT IS A MINOR, THE PARENT
ACCOMPANYING THE PATIENT IS RESPONSIBLE FOR ALL CHARGES>

Emergency Contact _____

Address _____

Phone Number _____

Patient's Employer _____
(if a minor child, responsible party's employer)

Employer's Address _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Method of Payment:

Cash Check Credit Card

PATIENT INFORMATION

Clay Eye Physicians & Surgeons may file your insurance if you allow us to verify your insurance information by obtaining a copy of your card & driver's license at each visit.

Primary Insurance Co. _____ HMO? Yes No

Policyholder's Name _____

Date of Birth _____ Social Security # / ID # _____

Secondary Insurance Co. _____ HMO? Yes No

Policyholder's Name _____

Date of Birth _____ Social Security # / ID # _____

Other Insurance _____ HMO? Yes No

Policyholder's Name _____

Date of Birth _____ Social Security # / ID # _____

Signature Authorization

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described. I authorize payment of Medigap coverage to be made on my behalf to Clay Eye Physicians & Surgeons for any services. If I do not follow my insurance guidelines, I understand that I will be responsible for payment. I understand if for any reason my insurance does not pay for services rendered, I will be held personally responsible for payment in full. I have read and understand all statements contained in this form and my signature below authorizes treatment.

Signed (Patient Signature) _____

Name (Please Print) _____