

**WELCOME TO OUR OFFICE**

Professional Eyecare Center-Dr. Tim Bengtson

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer(or school) \_\_\_\_\_ Occupation(or grade) \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_

Name, address, and number of primary insurance company \_\_\_\_\_

Name, address, and number of supplemental insurance company \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Or, how did you learn about our office? Phone Book Newspaper Other

**CONSENT FOR TREATMENT**

Dr. Tim Bengtson is herewith authorized to render service, medication, and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Tim Bengtson is a participating Medicare provider.

**INSURANCE RELEASE**

I authorize the release of medical information contained in my medical records to family physicians, and/or insurance companies. A photocopy of this authorization shall be as valid as the original. I assume responsibility for any balance above insurance.

**MEDICARE LIFETIME CONSENT**

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Tim Bengtson for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and it's agents any information needed to determine these benefits or the benefits payable to the related services.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

MEDICARE NUMBER(IF APPLICABLE) \_\_\_\_\_

**PAYMENT FOR SERVICES IS EXPECTED AT THE TIME SERVICES ARE RENDERED.**

**ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS.**