Tozer Eye Center
Randall K. Tozer, M.D.
Eye Physician and Surgeon
Diplomate American Board of Ophthalmology

Legal Name _____
LAST FIRST MI

Address _____
STREET APT# CITY ZIP

Mailing Address _____
(If different from above) STREET APT# CITY ZIP

Home Phone _____ Work _____ Cell _____

Email _____

SS# _____ Birth Date _____ Sex: Male ❑ Female ❑

Occupation _____ Employer _____

Spouse's Name _____ Primary Care Physician _____

RESPONSIBLE PARTY _____ Phone _____ Relationship _____
(If different from above)

Address _____
STREET APT# CITY ZIP

Emergency Contact _____ Phone _____

Primary Insurance _____ Policy Holder _____

Policy # _____ Group # _____ Policy Holder D.O.B. _____

Primary Address _____ Ins Phone _____

Secondary Insurance _____ Policy Holder _____

Policy # _____ Group # _____ Policy Holder D.O.B. _____

Secondary Address _____ Ins Phone _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company and/or Medicare to pay the doctor insurance or Medicare benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that I will be billed a fee for any returned checks.

_____ _____
Signature of patient or parent, if minor Date

How were you referred to our office?

❑ Doctor (Name: _____) ❑ Friend/Relative (Name: _____)

❑ Yellow Pages ❑ Reputation ❑ Other _____