



Perry J. Goodman, M.D. • Jonathan H. Moore, M.D.
1300 25th Avenue Meridian, MS 39301

First Name _____ Last _____ MI _____

Address _____

City _____ State _____ Zip _____

SS# _____ Date of Birth _____

Employer _____ Employer Phone _____

Home Phone _____ Cell Phone _____

Email Address _____

Marital Status (circle) S M W D Sex (circle) Male Female

Referring Physician _____ Family Physician _____

Emergency Contact _____ Phone _____

Are we allowed to give out your patient information to anyone? Yes _____ No _____

If yes list authorized people:

Name: _____ Phone _____

Name: _____ Phone _____

Please allow receptionist to copy your insurance cards and photo ID.

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Meridian Ophthalmic Associates, P.A., for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, I hereby authorize the release of any medical or other information necessary to process the insurance claim. I further agree that a photocopy of this agreement shall be as valid as the original.

Signed: _____ Date: _____