



D James Schumer, MD

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Patient Information:

Name: (Last) (First) (MI)
Address City State Zip
Date of Birth Age Sex Social Security #
Home Phone Business Phone Cellular
Employer Occupation
Address City State Zip
E-mail Address Referred by

In Case of emergency notify: Phone

Marital Status (please circle): Married Single Other

Spousal/Parent Information:

Name Date of Birth SS#
Address if different from patient
Employer Occupation
Address City State Zip

Primary Insurance

Name of Insurance ID# Group #
Insurance Address
Subscriber's Name Relationship DOB
Address if different from patient

Secondary Insurance

Is patient covered by additional Insurance? Name of Insurance
Insurance Address ID# Group #
Subscriber's Name Relationship DOB
Address if different from patient

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned companies and assign directly to ReVision all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature on all insurance submissions. I acknowledge that I am financially responsible for all unpaid debt as a result of services performed at this facility, as well as payment for procedures that my policy will not cover. To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of my medical records.

Signature Date