

OPHTHALMOLOGY ASSOCIATES, P.S.C.
PATIENT INFORMATION

DATE _____ ACCT # _____
DR. # _____
NAME: LAST _____ FIRST _____ MID. INIT. _____
ADDRESS: _____
CITY _____ STATE _____ ZIP _____
HOME PH # _____ CELL # _____ WORK # _____
BIRTH DATE _____ AGE _____ SEX _____
SOCIAL SECURITY # _____ REFERRING MD _____
EMPLOYER _____
ADDRESS _____
EMAIL ADDRESS FOR PATIENT PORTAL _____

Person with whom we may share your medical and financial records: _____
Relationship: _____

IS THIS A WORKMAN'S COMP VISIT? _____ **ACCIDENT DATE** _____
WORKMAN'S COMP CLAIM # _____
WORKMAN'S COMP BILLING NAME AND ADDRESS _____

ARE YOU IN A SKILLED NURSING CARE FACILITY? _____
NAME AND ADDRESS OF THE FACILITY _____

PRIMARY INSURANCE _____
SUBSCRIBERS NAME _____ DOB _____
POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE _____
SUBSCRIBERS NAME _____ DOB _____
POLICY NUMBER _____ GROUP NUMBER _____

CIRCLE ONE

RACE: AMERICAN INDIAN NATIVE AMERICAN ASIAN WHITE DECLINE TO ANSWER BLACK OR AFRICAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER OTHER
ETHNICITY: HISPANIC OR LATINO NON HISPANIC OR LATINO UNKNOWN DECLINE TO ANSWER

PHARMACY NAME _____ **ADDRESS** _____ **ZIP** _____
PHONE# _____

SPOUSE OR ALTERNATE CONTACT

NAME: LAST _____ FIRST _____ MID INIT. _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PH# _____ CELL # _____ WORK # _____
RELATIONSHIP TO PATIENT _____
ALTERNATE PHONE NUMBER _____

AUTHORIZATION: I HEREBY AUTHORIZE THE PHYSICIAN INDICATED ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS/ACCIDENT. I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

DATE _____

RESPONSIBLE PARTY SIGNATURE _____