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 _____

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*

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