

PARK OPHTHALMOLOGY

PATIENT INFORMATION

PATIENT NAME: _____ DATE _____

PHONE (h) _____ (w) _____ (cell) _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

AGE _____ BIRTHDATE _____ SEX _____ SOCIAL SECURITY # _____

PATIENTS DRIVERS LICENSE # _____ STATE _____

EMPLOYER _____ FAMILY PHYSICIAN _____ CITY _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

SPOUSE'S NAME _____ SPOUSE'S WORK PHONE _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY ? _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL ? _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____ SUBSCRIBER ID# _____

SECONDARY INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____ SUBSCRIBER ID # _____

SIGNATURE ON FILE

I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION. I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I AUTHORIZE USE OF THIS INFORMATION ON ALL MY INSURANCE SUBMISSIONS. I AUTHORIZE RELEASE OF INFORMATION TO ALL INSURANCE COMPANIES AND FOR MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT.

SIGNATURE : _____ DATE: _____

PARENT SIGNATURE (IF MINOR) _____ DATE: _____