PARK OPHTHALMOLOGY

PATIENT INFORMATION

PATIENT NAME _____ DATE _____

PHONE (H)_____ (W) _____ (CELL) _____

EMAIL _____

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 _____ SPOUSES WORK PHONE_____

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

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ SUBSCRIBER'S NAME_____

SUBSCRIBER DOB_____ SUBSCRIBER SS#_____ SUBSCRIBER ID#_____

SUBSCRIBER 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_____