Ophthalmology
Physicians & Surgeons, PC

Eye Care
Physicians & Surgeons

Form Help - Tab key-Moves to the next selection. Enter Key-Toggles selection between Checked or Un-Checked. Option Box Groups-Arrow Keys-Checks and moves from 1 option box in the group to the next. After checking the appropriate box, press the tab key to leave the option group.

Patient Name: _____
Last First Middle

Home Address: _____

City:_____ State: _____ Zip:_____

Home #: _____ Cell #: _____ Work #: _____

Social Security Number: _____ Date of Birth: _____ Gender ◯ Male ◯ Female

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed Spouse/Parent name: _____

E-mail address_____Preferred Contact Method: ◯ Home ◯ Cell ◯ Work

Primary Care Doctor (Doctor, not group name): _____

Who can we thank for your referral? _____

Emergency Contact Name: _____ Phone #: _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ White ☐ Other Ethnicity: ◯ Hispanic ◯ Non-Hispanic

MY SPECIALISTS (Doctor, not group name):

Rheumatologist: _____ Endocrinologist: _____

Oncologist: _____ Other Specialist: _____

INSURANCE INFORMATION:

Do you have Medical Insurance? ◯ Yes ◯ No

Do you have a Vision Plan/Insurance? ◯ Yes ◯ No

Is this Worker's Compensation? ◯ Yes ◯ No

Is this an Accident? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR PAYMENT (if the patient is a minor, please complete with information for a parent or guardian responsible for payment):

Name: _____ Address: _____

Phone: _____ Social Security Number: _____ DOB: _____

Relationship to patient: _____

I have received a copy of Ophthalmology Physicians & Surgeons Notice of Privacy Practices (this can be downloaded from our home page).

_____ _____
Patient's signature **today's date**

I hereby authorize Ophthalmology Physicians & Surgeons to provide treatment and services to myself and/or the above named patient. I also authorize the release for any and all necessary information to my insurance carrier(s) for direct processing to Ophthalmology Physicians & Surgeons. Payment is expected at the time of visit unless alternative arrangements have been made prior to your visit.

_____ _____
Patient's signature **today's date**

RESET PRINT