ASSOCIATE OPHTHALMOLOGISTS

Patient Demographics

NAME:_____MARITAL STATUS: (CHECK ONE) S M D W GENDER: (CHECK ONE) M F

ADDRESS:_____APT:_____CITY:_____STATE:_____ZIP_____

DATE OF BIRTH:_____AGE:_____SS#:_____EMAIL:_____

RACE:_____ETHNICITY:_____ LANGUAGE(S):_____

HOME#_____CELLPHONE#_____WORK#_____

EMPLOYER:_____OCCUPATION:_____

EMERGENCY CONTACT NAME:_____PHONE#_____RELATIONSHIP:_____

IS ANYONE ELSE AUTHORIZED TO RECEIVE CONFIDENTIAL INFORMATION:_____

MEDICAL INFORMATION

WHO REFERRED YOU TO THIS OFFICE? _____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? (CHECK ONE) ☐ YES ☐ NO

NAME OF PHYSICIAN:_____PHONE:_____

PHYSICIAN OFFICE ADDRESS: _____

IS THIS A WORK-RELATED INJURY? (CHECK ONE) ☐ NO ☐ YES:

IF YES, HAS YOUR EMPLOYER BEEN NOTIFIED? (CHECK ONE) ☐ YES ☐ NO

ACCIDENT DATE:_____SUPERVISOR NAME AND NUMBER_____

INSURANCE INFORMATION

MEDICAL INSURANCE (PRIMARY)_____SECONDARY (IF APPLICABLE)_____

DO YOU HAVE A VISION PLAN? (CHECK ONE) ☐ YES ☐ NO (DAVIS/ EYEMED/VSP/SPECTERA/SUPERIOR/NVA)

SUBSCRIBER, IF OTHER THAN PATIENT (CIRCLE) SPOUSE/PARENT/OTHER AND RELATION_____

NAME OF SUBSCRIBER_____DATE OF BIRTH_____SS#:_____

DO YOU HAVE A HEALTH SPENDING ACCOUNT? (CHECK ONE) ☐ YES ☐ NO

PLEASE READ AND SIGN BELOW

I (INITIAL) (_____) AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **ASSOCIATE OPHTHALMOLOGISTS** AND AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR OBTAINING A REFERRAL (OR WHERE APPLICABLE, NOTIFYING MY PRIMARY CARE PHYSICIAN) PRIOR TO MY VISIT AND THAT ALL COPAYMENTS, DEDUCTIBLES AND NON COVERED SERVICE ARE MY RESPONSIBILITY. I HAVE REVIEWED AND RECEIVED A COPY OF **ASSOCIATE OPHTHALMOLOGISTS, NOTICE OF PRIVACY PRACTICES.**

PATIENT/PARENT/GUARDIAN SIGNATURE_____ DATE_____