

Welcome to EYESIGHT OPHTHALMIC SERVICES

Please fill out the following form as completely as possible

Patient Name: _____

Sex: M F Date of Birth: _____

Street Address: _____

Marital Status: S M D unspecified

Social Security #: _____

Mailing Address: _____

Home Phone #: _____

Cell Phone #: _____

Employer: _____ Occupation: _____

Work phone #: _____

Employer Address: _____

Drivers Lic #: _____

PCP: _____ Address: _____

e-mail: _____

Responsible Party (if under 18 or student or different from above) Relationship to patient: _____

Name: _____ Sex: M F Date of Birth: _____

Street Address: _____ Social Security #: _____

_____ Home Phone #: _____

Mailing Address: _____ Work phone #: _____

Drivers Lic #: _____

Emergency Contact person: _____ **Phone #** _____

Insurance Information: (please show all insurance cards to receptionist)

Primary Subscriber to insurance: Name: _____ Sex: M F Date of Birth: _____

Employer: _____ Social Security #: _____

Employer Address: _____ Work phone #: _____

Is any portion of your eye exam covered by insurance? Y N

Do you have a co-payment due at the time of service? Y N Method of payment: Cash Check Visa MC

Any allergies to any medications: Yes No (if yes, please specify)

Do you have any medical problems: Yes No (if yes, please specify)

Please list all medications (including vitamins, contraceptives, and over the counter medications/herbal medicine taken regularly):

<u>Medication</u>	<u>Dose</u>	<u>How often</u>	<u>Medication</u>	<u>Dose</u>	<u>How often</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(continue on the back of this sheet if necessary.)

Referred By: Physician _____ Family/Friend _____ Verizon Yellow Pages Radio TV

Are you interested in information on any of the following (please circle):

Contact lenses Laser refractive surgery Sports glasses Sunglasses Other _____

Have you ever been seen by any of the doctors at Eyesight before? _____ When? _____

I authorize Eyesight Ophthalmic Services, P.A. to release information to my insurance carrier, employer, referring physician, or other physicians regarding my treatment and/or illness. I authorize Eyesight Ophthalmic Services, P.A. to submit to my insurance with the understanding that I am responsible for any fees not covered by my insurance at the time of service.

Signature: _____

Date: _____