

NEW PATIENT INFORMATION FORM

Patient # _____ Date _____
Name _____ Age _____ Sex _____ Marital Status _____
Birth Date _____ SS # _____ Tel: Home () _____ Work () _____
Address _____ City _____ Zip Code _____
Employer (parent's employer if patient is a minor) _____
Occupation _____ Address _____
Spouse's Name _____ Spouse's Employer _____
(or Parent's Name)
Emergency Contact _____ Phone number () _____
Primary Care Physician _____

EYE HISTORY: Have you ever had any of the following (Check):

- Eye surgery Eye Injury Glaucoma Cataract
 Crossed or lazy eye Retinal Detachment Other

Referred by:

Physician: _____

Friend: _____

MEDICAL HISTORY: Do you have any of the following (Check):

- Diabetes High blood pressure Cancer Heart disease
 Hay fever/allergies Nervous/Psychiatric Stroke
 Thyroid disease Rheumatoid arthritis Other _____

Yellow pages: _____

Other: _____

Please List any hospitalizations: _____

Date _____ Reason _____

Date _____ Reason _____

Please list any medications your are taking

Other Information

Allergy to medicine No Yes (please list) _____

Please check box for FAMILY HISTORY of:

- Retinal Detachment Glaucoma Crossed eye/Lazy eye Other

INSURANCE

Primary Insurance Company

Secondary Insurance Company

Subscriber's Name and Date of Birth

Subscriber's Name and Date of Birth

Plan

Plan

Policy #

Group #

Policy #

Group #

Copay

Copay

All Professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible of all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-150 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Signature: _____

Date: _____