

PATIENT INFORMATION

Date: _____

Patient's Name: _____ Email Address: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: (_____) _____ Work #: (_____) _____ Date of Birth: _____
Social Security #: _____ Circle Sex: M F Marital Status: _____
Patient's Employer: _____ Occupation: _____
Contact in Case of Emergency: _____ Phone # _____
Primary Care Doctor: _____ Referring Doctor _____
How did you hear about us: TV Ad _____ Yellow Pages _____ Church Bulletin _____ Radio Ad _____ Family/Friend _____

Insurance Information: (Please give receptionist your card.)

Primary Insurance Co: _____ Phone #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID # _____ PT Policy ID #: _____ Group #: _____
Insured DOB: _____ Insured SS #: _____ Ins. Employer: _____ Emp. Phone # _____

Secondary Insurance Co: _____
Insurance Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID #: _____ PT Policy ID #: _____ Group #: _____
Insured DOB: _____ Insured Employer: _____ Employer Phone #: _____

If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other: _____

DO YOU HAVE VISION COVERAGE? YES _____ NO _____

Name of vision carrier: _____

Name of insured: _____ Insured Date of Birth: _____ Relation to Patient: _____

IS THIS A WORKER'S COMPENSATION INJURY? YES _____ NO _____

Employer at time of injury: _____ Claim # _____ Date of Injury _____

IF PATIENT IS A MINOR:

Mothers's Name: _____ Date of Birth: _____ Phone: _____

Mother's Employer: _____ SS #: _____ Bus. Phone: _____

Father's Name _____ Date of Birth: _____ Phone: _____

Father's Employer: _____ SS #: _____ Bus. Phone: _____

CONSENT FOR TREATMENT:

I understand that medical treatment may be necessary and I hereby consent to authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgment of the physician. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of my examination, care, and treatment.

RELEASE OF INFORMATION:

I hereby authorize my physician and Eye Care Associates of Greater Cincinnati to release any information acquired in the course of my examination or treatment to insurance carriers, 3rd party payers, Health Care Financing Administration and it's agents or others requesting information needed to determine benefits.

PAYMENT IS REQUESTED AT THE TIME OF SERVICE:

I have read and understand the Eye Care Associates FINANCIAL AGREEMENT.

I acknowledge that I am responsible for payment to Eye Care Associates of Greater Cincinnati for services rendered. I hereby authorize that benefits from insurance carriers be paid directly to Eye Care Associates of Greater Cincinnati or my physician. I am financially responsible for any non-coverage services. I further request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to my physician for any services furnished by my physician.

Date: _____ Signed _____