

Ophthalmology Associates, S.C.

A Multi-Specialty Eye Care Practice

Legal Name: _____ Sex: M / F SSN# _____
(Last) (First) (Middle)

Street Address: _____ Apt. # _____ Date of Birth ____/____/____

City: _____ State: _____ Zip code: _____ Home Phone: _____

Cell Phone: _____ E-Mail: _____

Employer: _____ Work Phone: _____ Marital Status: M W S D

Emergency Contact: _____ Relationship to patient: _____ Phone Number: _____

Primary Care Physician ? _____ Did this doctor refer you here today? Y/N

Do you see a Rheumatologist? _____ Did this doctor refer you here today? Y/N

If an Optometrist referred you here today what is their name? _____

Location/Phone Number: _____

How did you hear about Ophthalmology Associates, S.C.? _____

PREFERRED LANGUAGE (Circle One) : English Spanish Other _____ Prefer Not To Answer

Parent/ POA/ Legal Guardian: _____ Send bills here? Yes or NO

Relationship to patient: _____ Responsible party D.O.B. ____/____/____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip code : _____ Phone Number: _____

INSURANCE INFORMATION

(Card copies must be provided to ensure proper claims mailing address)

PLEASE FILL OUT ALL AREAS IN FULL – THIS IS IMPORTANT FOR ELECTRONIC SUBMISSION

	<u>Primary</u>	<u>Secondary</u>	<u>Vision (or Third)</u>
Insurance Name:	_____	_____	_____
Subscriber Name:	_____	_____	_____
Subscriber Date of Birth:	____/____/____	____/____/____	____/____/____
Relationship to insured:	_____	_____	_____
Member/Policy ID#:	_____	_____	_____
Group #:	_____	_____	_____
Employer:	_____	_____	_____

Today's Date: _____

Signature of Patient (if over 18) or Legal Guardian: _____