EYE ASSOCIATES OF BUCKS COUNTY

Date: ____/____/____ Acct. #_____ Sex: Male ___ Female ___

Name_____ Date of Birth ____/____/____
Last First Middle Initial Suffix Marital Status: S / M / W / D
Address
_____
Street Address Apt.# City State Zip Code
Social Security _____ Email Address
_____

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Primary Care Physician &Address _____ Phone #(_____) _____

Employer &
Address_____
_____

Insurance Information

Primary Carrier_____ ID # _____ Grp. # _____
Name of Subscriber_____ Relationship to Subscriber ___Self ___Spouse ___Parent
Subscriber's Employer_____ Subscriber's DOB ____/____/____ SS #_____
Secondary Carrier_____ ID # _____ Grp. # _____
Subscriber _____ Relation to Patient _____ Subscriber's DOB ____/____/____ SS #_____

Person Responsible for Bills

Name: Self or _____
Address:_____
Relationship to Patient_____ DOB ____/____/____ Phone # (_____) _____

PATIENT/FAMILY HISTORY

	Self	Family		Self	Family
Diabetes	_____	_____	Thyroid	_____	_____
High Blood Pressure	_____	_____	Tuberculosis	_____	_____
Arthritis	_____	_____	Cancer	_____	_____
Cataracts	_____	_____	Heart	_____	_____
High Cholesterol	_____	_____	Kidney	_____	_____

List medications presently taking:
_____
Allergies to medications:
_____
Family history of eye problems (other than glasses):
_____
Previous eye injury or surgery:
_____

Previous surgery pertaining to general health:
_____

Do you wear Glasses __ Contacts __ / Do you smoke? __ How much? _____ / Do you drink alcohol? __ How much? _____

Reason for today's visit?
_____

ASSIGNMENT AND RELEASE

I hereby authorize Eye Associates of Bucks County to release information necessary to insurance carriers concerning
my illness and treatment. I hereby assign all medical and/or surgical benefits direct to Eye Associates of Bucks
County. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be
considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by
said insurance.

Signature_____Date_____
_____

MEDICARE BENEFITS

"I request that payment of authorized Medicare benefits be made on my behalf to Eye Associates of Bucks County for
any services furnished me by that physician or supplier. I authorize any holder of medical information about me to
release to Health Care Financing Administration and its agents any information needed to determine these benefits or
the benefits payable to related services."

Signature_____
Date_____

PRIVACY NOTICE

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's
Notice of Privacy IN THE RECEPTION AREA. You are not required to read this Notice. However, we would like
your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Signature_____
Date_____

I authorize Eye Associates of Bucks County to release information regarding my medical condition to the
following:

NAME AND ADDRESS PHONE NO. RELATION TO PATIENT