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 # (_____) _____

Referred by _____

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

Employer & Address_____

Pharmacy & Phone #: _____

PATIENT/FAMILY HISTORY

	Self	Family		Self	Family
Diabetes	_____	_____	Thyroid	_____	_____
High Blood Pressure	_____	_____	Cancer	_____	_____
Arthritis	_____	_____	Heart	_____	_____
Autoimmune Disease	_____	_____	Kidney	_____	_____
High Cholesterol	_____	_____	Other	_____	_____

List medications presently taking: _____

Allergies to medications: _____

Family history of eye disease (including Glaucoma & Macular Degeneration): _____

_____

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? _____

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

tmg023

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 # (____) _____

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_____