EYE PHYSICIANS AND SURGEONS OF COLUMBIA, PA
PATIENT INFORMATION

Pharmacy Name_____

DATE_____ Email Address _____ Address _____

Patient Name Last_____ First_____ M.I. _____ Gender M / F

Patients SS # _____ _____ _____ Birthdate _____ Age _____ Race _____

Home Address _____ City _____ State _____ Zip _____

Phone # Home_____ Work _____ Cell _____

Marital Status- Single / Married / Divorced / Widowed Driver's License # _____

[If Minor Responsible Party _____ SS # _____ _____ _____]

Patient's Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse Name _____ Birthdate _____ Spouse Work Phone _____ Cell # _____

Primary Care Physician _____ Referred By _____

PRIMARY INSURANCE _____ Policy # _____ Group # _____

Insured's Name _____ Birthdate _____ Relationship _____

SECONDARY INSURANCE _____ Policy # _____ Group # _____

Insured's Name _____ Birthdate _____ Relationship_____

(May we leave a message on cell phone/answering machine if necessary [ ] Yes [ ] No)

EMERGENCY CONTACT _____ Relationship _____Cell # _____
(not living with you)

I authorize reports of my evaluation, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that I have or will identify to you. I authorize any holder of medical of medical or other information about me, to release to the Social Security Administration and The Center for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if this is a Workmen's Compensation claim, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all cost of collection agency fees, attorney fees and court cost, if any.

SIGNATURE:_____ DATE _____

I acknowledge that Eye Physicians and Surgeons of Columbia, P.A has given me a copy of the Notice of Privacy Practices.

SIGNATURE: _____ DATE _____