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

Street Address: _____ Apt. # _____ Date of Birth____/_____/_____

City_____State_____ Zipcode_____Phone Number ( ) _____ -_____

May we contact you by e-mail? __Y __N E-Mail Address: _____

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

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

RACE (*Circle One*) : White Black Asian Native Hawaiian American Indian Prefer Not To Answer

ETHNICITY (*Circle One*) : Hispanic Origin Non-Hispanic Origin Prefer Not To Answer

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Parent/ POA/ Legal Guardian_____ Send bills here? Yes or NO

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

Street Address:_____ Apt#_____

City_____ State_____ Zipcode_____ Phone number: ( )_____-_____

Who is your family doctor?_____ Did this doctor refer you here today? Y/N

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

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

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

I have reviewed the MEDICATION NOTICE and ASSIGNMENT OF INSURANCE BENEFITS on the back.

Todays Date:_____

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

Subsequent visits: I verify that the information above has not changed in anyway.

Initials:_____ Date:_____

Initials:_____ Date:_____

MEDICATION NOTICE

By signing, I give consent to the staff of Ophthalmology Associates, S.C. to view my prescription history as supplied by other health plans and with participating pharmacies. My signature also indicates I have provided Ophthalmology Associates S.C. with my most current demographic and insurance information.

ASSIGNMENT OF INSURANCE

I hereby authorize Ophthalmology Associates, S.C. to release any medical information necessary for the processing of my claims to my insurance carrier and/or my attorney indicated below. I understand this information could include discharge summary, history, and physical. Surgical reports, X-ray and lab results. I authorize direct payment to Ophthalmology Associates, S.C., of any insurance benefit and/or settlement for expenses incurred at his offices which would otherwise be payable to myself, I understand that I am financially responsible for any charges not covered by insurance and/or settlement of my claim. I affirm that I have provided Ophthalmology Associates, S.C., with all and any of my insurance coverage information. I understand that if I withhold any insurance information, which would prevent Ophthalmology Associates, S.C., from billing any of my insurance carriers' properly, those charges would be my responsibility.

MEDICARE PATIENT: I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.