## Patient Information

Please print Date_____

Name _____ Telephone# (Home)_____(Mobile)_____
last first middle

Street address_____Apt #_____City_____State____Zip_____

Sex M F Age_____ Birthdate____/____/_____SS#_____

In case of an emergency, contact_____Telephone#_____

Name of nearest relative (not living with you)_____Telephone#_____

**If the patient is a child please fill out this section**

Name of Father_____SS#_____

Name of Mother_____SS#_____

**If the patient is an adult please fill out this section**

Single Married Other E-mail_____Occupation_____

Employer_____Telephone # (Work)_____

Business address_____

_____

Name spouse_____Occupation_____

Phone# where you can be reached between 9:00 AM and 5:00 PM_____

## PHYSICIAN INFORMATION

Name of your primary care physician_____Telephone#_____

Where is his/her office_____

Name of your pharmacy_____Telephone#_____

Who may we thank for referring you?_____

## HEALTH INSURANCE COVERAGE

PLEASE INCLUDE ANY LETTERS WITH ID#. COPY OF INSURANCE CARD NEEDED

1st_____ID#_____Group #_____

2nd_____ID#_____Group#_____

**IF THE NAME OF THE INSURANCE POLICYHOLDER IS <u>OTHER</u> THAN THE PATIENT, PLEASE COMPLETE**

Name of Policyholder_____

Address of Policyholder_____

SS# of Policyholder_____Date of birth_____

Employer of Policyholder_____Employer's Address_____

**METHOD OF PAYMENT**

Insurance Cash Check

## PLEASE READ!

All charges are due at the time the services are rendered unless other arrangements are made in advance. You, the patient, are ultimately responsible for knowing your own coverage. If you do not know whether services will be covered by your insurance we suggest calling the telephone number on the back of your insurance card to verify coverage**.** If you still have any questions please call us or ask your primary care physician before services are provided.

**If a referral is needed and not received at the time of service, you will be billed for services provided.**

If we do not participate with your insurance company, please attach a copy of your receipt to your insurance form and mail it to your insurance company. All the necessary information for your insurance company will be found on your receipt.

Our office will make every reasonable attempt to verify insurance coverage and determine eligibility for covered services. However, because of the proliferation of health insurance plans we cannot always determine eligibility ahead of time.

As a convenience to our patients we may bill third party insurance companies for covered services. If payment from insurance companies is not received within 60 (sixty) days, you may be responsible for contacting your insurance company to determine payment status.

***If you will be unable to keep your appointment please notify our office at least 24 hours in advance. This will allow us to offer that appointment to other patients.***

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to **Bucks County Eye Group** for professional services rendered. I understand I am financially responsible for all charges not covered by my insurance.

Signed_____
Subscriber

**RELEASE OF INFORMATION**

I authorize the release of any and all information necessary to process my insurance claim.

Signed_____
Patient (or Parent, if minor)

**IF THERE ARE ANY CHANGES IN YOUR ADDRESS, PHONE NUMBER, INSURANCE INFORMATION, ETC. BETWEEN VISITS, PLEASE NOTIFY OUR OFFICE.**