

MIDATLANTIC OPHTHALMOLOGY

PATIENT INFORMATION

DATE: ____ / ____ / ____

Last Name: _____ First Name: _____ MI ____ Marital Status: S M W D

Birthday: _____ Sex: M / F Height: _____ Weight: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Social Security# _____ Home Phone: _____

Street Address: _____ City: _____ ST: _____ Zip: _____

Patient's employer: _____ Occupation: _____ Work Phone# _____

Employer's address: _____ City & State: _____ Zip _____

Spouse or Parent's name: _____ Address: _____ Zip _____

Spouse or Parent's Employer: _____ Occupation: _____ Phone # _____

Employer's Address: _____ City & State: _____ Zip _____

Have you or anyone in your family been here before: Yes ____ No ____ which Doctor _____

How were you referred to this office: _____ Family Doctor: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Address: _____

Subscriber's name: _____ Birth date: _____ ID# _____ Group# _____

Secondary Insurance Co: _____ Address: _____

Subscriber's name: _____ Birth date: _____ ID# _____ Group# _____

IF PATIENT IS NOT RESPONSIBLE FOR BILL, PLEASE FILL IN THE FOLLOWING

Guarantor: _____ Home Phone# _____ Work Phone # _____

Address: _____ City & State _____ Zip _____

Birth date: _____ Social Security# _____ Sex M F Employer _____

I understand that Medicare and most insurance companies DO NOT PAY FOR REFRACTION when needed to assess the best corrected visual acuity or to prescribe glasses. Medicare and many insurance companies do not cover routine eye examinations. Medicare will not pay for routine eye exams.