TODAY'S DATE: _____________ **AGE:** ________ **MARITAL STATUS (S M W D)**

RACE: ___________________ **LANGUAGE:** ___________________ **ETHNICITY:** _______________

DATE OF BIRTH: _____________________

PATIENT'S NAME: ____________________________________ **SEX: (M F)**

ADDRESS: ____

Street City State Zip

HOME PHONE: ___________________________ **WORK PHONE:** ____________________________

CELL PHONE: ____________________________ **E MAIL:** ___________________________________

IS IT OKAY TO LEAVE A MESSAGE ON ANSWERING MACHINE/VOICE MAIL? ___Yes or ___No

IF SO PLEASE SPECIFY WHICH PHONE(S) ____

EMPLOYER: ______________________________ **OCCUPATION:** ____________________________

WORK ADDRESS: ____

Street City State Zip

EMERGENCY CONTACT: ____

Name Phone Relation

INSURANCE INFORMATION

MEDICAL DOCTOR: ____

PRIMARY INSURANCE: ___________________ **POLICY HOLDER'S NAME:** _________________________

SOCIAL SECURITY NUMBER: ______________________ **DATE OF BIRTH:** _________________________

POLICY NUMBER: _________________________________ **GROUP NUMBER:** ________________________

SECONDARY INSURANCE: _________________ **POLICY HOLDER'S NAME:** ________________________

SOCIAL SECURITY NUMBER: ______________________ **DATE OF BIRTH:** _________________________

POLICY NUMBER: _________________________________ **GROUP NUMBER:** ________________________

HOW DID YOU HEAR ABOUT OPHTHALMOLOGY ASSOCIATES, LTD.? Please check one of the following.

____FAMILY ____FRIEND ____PHONE BOOK ____OTHER (Please specify)________________________

RELEASE OF INFORMATION-PAYMENT AUTHORIZATION

I authorize my insurance company to pay benefits directly to Ophthalmology Associates, Ltd. I am financially responsible for any unpaid balance on my account. Unless I make prior arrangements, I will pay "out of pocket" charges at time of service. If I default and do not pay, Ophthalmology Associates, Ltd. is entitled to the right of recovery of all collections expenses up to 35%, including all court costs and reasonable attorney's fees incurred for the purpose of securing payment, if I am named the insured. I agree that any credit balance on an account of any family member may be applied to the account of anyone else in my family.

By signing this I have read and understand my financial responsibilities.

____ _________________________

Patient Signature **Date**

____

Parent/Guardian (If patient is under the age of 18)