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Patient Information (please print – use black ink only)

Patient Name: (Last) _____ (MI) _____ (First) _____
 Street Address: _____ E-mail: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: (____) ____ – _____ Work Phone: (____) ____ – _____ Cell Phone: (____) ____ – _____
 Birth Date: ____ / ____ / ____ Age: ____ SS#: ____ – ____ – ____ M F Race: _____
 Marital Status: Single Married Widowed Divorced Separated (Spouse's Name:) _____

Emergency Contact, other than Spouse (not living with you)

Name: _____
 Home Phone: (____) ____ – _____ Work Phone: (____) ____ – _____ Cell Phone: (____) ____ – _____
 Relationship to Patient: _____

Referring Physicians

Who may we thank for referring you to our office?: _____

Referring Physician: _____ Office Phone: (____) ____ – _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Office Phone: (____) ____ – _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Personal Optometrist: _____ Office Phone: (____) ____ – _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employment

Patient's Employer (or retired from): _____

Street Address: _____ Work Phone: (____) ____ – _____

City: _____ State: _____ Zip Code: _____

Spouse's Employer (or retired from): _____

Street Address: _____ Work Phone: (____) ____ – _____

City: _____ State: _____ Zip Code: _____

INSURANCE COVERAGE

Please provide your insurance and I.D. cards for photocopying.
If this form is not filled out in its entirety, you may be responsible for payment services.

Responsible Party (if different than patient or spouse): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: ____ / ____ / ____ SS#: ____ - ____ - ____ Relationship to patient: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

Primary:

Insurance Company Name: _____

Policy No.: _____

Group No.: _____

Subscriber's Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Social Security No.: ____ - ____ - ____

Subscriber's Date of Birth: ____ / ____ / ____

Secondary:

Insurance Company Name: _____

Policy No.: _____

Group No.: _____

Subscriber's Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Social Security No.: ____ - ____ - ____

Subscriber's Date of Birth: ____ / ____ / ____

Third:

Insurance Company Name: _____

Policy No.: _____

Group No.: _____

Subscriber's Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Social Security No.: ____ - ____ - ____

Subscriber's Date of Birth: ____ / ____ / ____

Worker's Compensation:

Claim No: _____

Date of Injury: ____ / ____ / ____

Employer at time of injury: _____

Address: _____

City/State/Zip: _____

Telephone No.: ____ - ____ - ____

Contact Person: _____

MCO: _____

I authorize the release of any medical information by Ohio Eye Associates, Inc. for any insurance claims submission and at the doctor's discretion, assign the insurance payment to them for these services. I understand that I am financially responsible for the charges that are not covered.

Patient (or Responsible Party) Signature: **X** _____

Date: ____ / ____ / ____