Central Bucks Ophthalmology

New Patient Information Form

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Driver's License: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

Payment Method: _____ Cash/Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Name Date