PHOENIXVILLE
EYE CARE SPECIALISTS

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Ophthalmology
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PLEASE PRINT CLEARLY **TODAY'S DATE** _____

Patient's Name (Last, First, MI)_____ S. S. No._____

Patient's Address _____
Street *State* *Zip*

Patient's Telephone Number_____Mobile_____Work_____

Date of Birth _____ Sex M F Marital Status S M D W

Email Address _____

Primary Care Physician _____Address _____

Referring Physician _____Address_____

Pharmacy _____Address_____

Emergency Contact _____Telephone Number_____

If patient is a minor, parent's name_____

Person Responsible for Payment (and address) _____

I hereby authorize Phoenixville Eye Care Specialists to release to my insurance carriers any information concerning my examination and/or surgery. I hereby assign to Phoenixville Eye Care Specialists all payments for services rendered to myself or my dependents. Regardless of the insurance coverage or worker's compensation coverage I have, I agree I am ultimately responsible for the bill. If my account requires collection service, I realize I will be responsible for any collection costs.

(Must be signed prior to treating patient.) _____
Signature *Date*

Insurance Information – PLEASE PRESENT YOUR HEALTH INSURANCE CARDS TO RECEPTIONISTS.

Vision Insurance Co _____ ID# _____

Medical Insurance Co _____ID#_____

Subscriber's Name_____ Subscriber's S.S. #_____

Subscriber's Birthdate _____Subscriber's Employer_____

Subscriber's Sex___M___F___Patient's Relationship to Subscriber_____