Patient Information Sheet

Date: _____ Last Update: _____

Patient Information:

Patient's Name _____ Gender: □ Male □ Female

Date of Birth _____ Age: _____ Ethnicity: □ Hispanic □ Non-Hispanic

Race: □ American Indian/Alaskan Native □ Asian □ African American □ Caucasian □ Other

Address _____ City _____ St ____ ZIP _____

Alt. Address (if not a FL resident) _____

Hm phone # _____ Alternate phone # _____ Marital Status _____

Email address (will only be used for future secure communication) _____

Drivers license # _____ St _____ SS # _____

Employers Name _____ Wk phone # _____

Referring Physician _____ General Physician _____

Guarantor or Guardian Information:

Guarantor/Guardian's Name _____ Relationship to patient _____

Date of birth _____ SS # _____

Permanent Address _____ City _____ St ____ ZIP _____

Hm phone # _____ Drivers License # _____ St _____

In Case of Emergency – Call _____

(someone not living with you)

Hm # _____ Wk # _____ Relationship _____

Insurance Information:

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Ins: _____	Name of Ins: _____
Policy owner: _____	Policy owner: _____
Pt. relationship to owner: _____	Pt. relationship to owner: _____
Policy ID #: _____	Policy ID #: _____
Group #: _____	Group #: _____

OVER

At Ophthalmic Consultants, P.A., we are participating Medicare providers and will file your Medicare claims and any applicable secondary insurance. Should you not be a Medicare recipient, as a courtesy to you, we will file your primary insurance. Any applicable co-pay and/or co-insurance is due **AT THE TIME OF SERVICE.** If extenuating circumstances exist and you are unable to do so, please request to speak to our Patient Accounts Representative. It is the **patient's** responsibility to know which providers are in **their** network and which services are covered by **their** plan, and that proper authorization is in place for services provided by Ophthalmic Consultants, P.A.

Assignment of Benefits – Authorization to Release Information – Financial Responsibility

I hereby assign all Medical/Surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to:

OPHTHALMIC CONSULTANTS, P.A.
1700 S TUTTLE AVE
SARASOTA, FL 34239

This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am ultimately responsible for all charges, whether or not paid by said insurance. I also understand that, should I default on my account, all costs of attorney's fees, interest and cost of collections would be my responsibility. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms on my behalf.

_____	_____	_____
Patient's Signature	Guarantor's Signature	Guardian's Signature

May we disclose information necessary for your care or for payment of your care to individuals that are part of your "circle of care", such as your spouse or other family member or an aide who may be assisting you?

I hereby authorize the doctors and staff members at Ophthalmic Consultants, P.A. to discuss my medical history /condition and or account information with the following family members and or representative (s):

_____	_____	_____
Name	Name	Name
_____	_____	_____
Relationship	Relationship	Relationship
_____	_____	_____
Name	Name	Name
_____	_____	_____
Relationship	Relationship	Relationship