ASSOCIATES IN OPHTHAMOLOGY, P.C.

John C. Hart, Jr., M.D., F.A.C.S. * Brian R. Sygiel, M.D. . * David M. Shepherd, M.D. * Jill R. Schnurer, O.D.

PATIENT:

Last Name ______________________ First Name ______________________ Middle ________

Birthdate ______________________ Social Security Number ______________________ Sex M F

E-Mail Address ______________________ Primary Language Spoken ______________________

Race: ☐ Asian ☐ African American ☐ Caucasian ☐ Other __________ ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Decline to answer Marital Status S M W D

Street Address ____

City ______________________ State ________ Zip Code ____________

Home Phone ( ) ______________________ Cell Phone ( ) ______________________

Emergency Contact Person ______________________ Emergency phone number ( ) ____________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

Last Name ______________________ First Name ______________________ Middle ________

Birthdate ______________________ Relationship to Patient ______________________

Street Address ______________________ State ________ Zip Code ____________

Home Phone Number ( ) ______________________ Alternate Phone Number ( ) ____________

PRIMARY CARE PHYSICIAN:

Name ____

Phone Number ( ) ______________________ Fax Number ( ) ______________________

HOW YOU WERE REFERRED HERE:

Doctor ______________________ Family/Friend ______________________

Employee ______________________ Other ______________________

It is your responsibility to be familiar with the terms, deductions, referral requirements and co-pays of your insurance company. Failure to provide us with the correct insurance information or follow their guidelines may result in non-covered expenses which will become your responsibility. If the doctor you are seeing doesn't participate with your insurance company, payment is due at the time of service and claims can be submitted for your reimbursement. In some cases, the portion of the exam which determines the power of glasses, also known as a refraction, is not covered by some insurances.

My signature below attests to the following: I have read these statements and wish to proceed with my exam(s), knowing I may be responsible for a portion or all of the charges. I agree to pay Associates in Ophthalmology, P.C. for all services not covered by my insurance company, deductibles and/or co-pays. I authorize the release of any medical information necessary for my insurance company to process this claim. I also authorize insurance payment of medical benefits to the physician for services rendered. I authorize release of medical information to subspecialists if deemed necessary by my physician.

SIGNATURE ______________________ **DATE** ______________________