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** _____