EXCELLENCE IN EYE CARE SINCE 1977

DONALDSON EYE CARE

MEDICAL AND SURGICAL OPHTHALMOLOGY

PATIENT INFORMATION

PERSONAL INFORMATION

Date _____ Thank you for answering each question

Name of Patient _____ **SOCIAL SECURITY #** _____

Mailing Address _____ City _____ State____ Zip _____

Physical Address (if different)_____ City _____ State____ Zip _____

Home Phone #_____ Cell Phone # _____

E-mail _____

Male___ Female___ Marital Status _____ Age _____ Date of Birth _____

Primary language spoken _____ Race _____

Do you have insurance through work? Yes___ No___ **Do you have insurance through your Spouse's work?** Yes___ No___

Are you currently working? Full-Time___ Part-Time___ Not Working ___ Retired___ Disabled___ Full Time Student ___

Employer _____ Work Phone #_____

Occupation _____ Employer's Address _____

Name of Spouse _____ Spouse's Date of Birth _____

Spouse's Social Security # _____ Spouse's Home Phone #_____ Spouse's Cell Phone # _____

Is your Spouse currently working? Full-Time___ Part-Time___ Not Working ___ Retired___ Disabled___ Deceased ___

Spouse's Employer _____ Work Phone # _____

Spouse's Occupation _____ Employer's Address _____

Is this treatment for a work related illness or injury? Yes___ No___ If Yes, provide Worker's Comp Information:

_____

Is this service to treat an illness or injury resulting from an automobile accident? Yes___ No___

If Yes, provide name, address and policy number of automobile or non-automobile liability or no fault insurer:

_____

Emergency Contact (not Spouse): _____ Phone # _____ Relationship? _____

If you are a new patient, how did you find out about us? _____

Primary Care Doctor _____

I hereby authorize payment of my medical and surgical insurance benefits to the above providers, as applicable. I understand I am financially responsible for any charge whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the above providers, as applicable. I authorize any holder of medical or other information about me to release any information required to process any and all claims for reimbursement on my behalf, or to treat my condition.

Copayments are due at the time of service. Most insurances require copays to be paid at the time of the visit. There may be a $25 patient charge for a second missed appointment without 24 hour notice.

After 90 days in patient responsibility without payment in full or payment arrangements, patient accounts will be sent to an outside collection agency. There may be an additional charge of $25.00 to any account sent to an outside collection agency.

Signature of Patient or Responsible Party _____