

Account # \_\_\_\_\_ (internal use)

**Patient's information**

Name: \_\_\_\_\_ Sex: M / F  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Marital Status: M / S / D / W Spouse's name: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Email address (optional): \_\_\_\_\_  
Patient's employer name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_

**Insured's information (if not patient) / Responsible party (for minors)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mailing address (if different than patient): \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's primary medical doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring doctor (if applicable): \_\_\_\_\_ Phone #: \_\_\_\_\_  
Patient's pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Insurance information**

Please put a **1** in front of your primary insurance.  
If you have secondary insurance, please indicate that by putting a **2** in front of it.  
If you have a third insurance, please indicate that by putting a **3** in front of it.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medicare                                    | <input type="checkbox"/> The Empire Plan    | <input type="checkbox"/> Self Pay              |
| <input type="checkbox"/> Medicaid (Seq. # <input type="checkbox"/> ) | <input type="checkbox"/> Healthquest        | <input type="checkbox"/> United Healthcare     |
| <input type="checkbox"/> AARP  | <input type="checkbox"/> Hudson Health Plan | <input type="checkbox"/> Wellcare              |
| <input type="checkbox"/> Aetna                                       | <input type="checkbox"/> Local _____ (#)    | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> CDPHP                                       | <input type="checkbox"/> MVP                | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Empire BCBS                                 | <input type="checkbox"/> No Fault           | <input type="checkbox"/> Other _____           |
|  | <input type="checkbox"/> Oxford             |  |

Primary insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Third insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

"I agree to be responsible for payment of all charges for services rendered to me or to the above named patient, regardless of whether those charges are covered by insurance. If the patient is a minor, the provider reserves the right to seek payment from both parents, regardless of custody arrangements or the provisions of any divorce or separation agreement."

"I have received a copy of Central New York Eye Center's Bill of Rights, which informs me of my patient rights, my responsibility to the Center, and guarantees that any Advanced Directives will be honored." \_\_\_\_\_

**"I DO / DO NOT have an Advanced Directive, such as a DNR, a Living Will, or a Health Care Proxy."**  
(circle one) (circle any that apply)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_