

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: _____