NEW PATIENT INFORMATION RECORD

Full Name: _____ SS#: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Home Address: _____ City: _____ State: _____

Email: _____ Home Phone: _____ Cell:_____

Primary Care Doctor: _____

Spouses Name: _____SS#: _____ DOB:_____

_____

If patient is a minor, the following information must be filled out by parent or guardian:

Father: _____ Mother: _____

Address: _____ Address: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

Home#: _____ Cell#: _____Home#: _____ Cell#:_____

_____

INSURANCE INFORMATION: (Insurance cards must be presented at EVERY visit)

Primary Health Insurance: _____ ID#: _____

Subscriber's Name: _____ SS#: _____DOB:_____

Subscriber's Employer: _____

Secondary Health Insurance:_____ ID#:_____

Subscriber's Name: _____ SS#: _____DOB:_____

Subscriber's Employer: _____

I hereby authorize Hometown Ophthalmology to treat my dependents or myself. I also authorize Hometown Ophthalmology to furnish information to insurance carriers concerning my/their illness and treatments. This authorization is valid as long as I am a patient of Hometown Ophthalmology. I understand that I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If my account is placed for collection with a third party collection agency, I agree to be responsible for pre and post-judgement interest, attorney fees, and court costs. I understand and agree to the above terms. I have received a Notice of Privacy Practices from Hometown Ophthalmology.

Signature of Patient or Responsible Party: _____Date:_____

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to me or on my behalf to Hometown Ophthalmology for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

MEDICARE SECONDARY INSURANCE

I request that payment of authorized Medicare benefits be made either to me or to Hometown Ophthalmology on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to (Secondary Insurance Name) _____ any information to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

Patient Medical History Form
Hometown Ophthalmology

Name _____

Who is your primary care doctor? _____

List any specialist doctors that you see: _____

Past Medical History: Circle any of the conditions that you have:

Diabetes	High Blood Pressure	Blood clots	Lung Disease
Heart Disease	History of Stroke	Bad reaction to anesthesia	
Cancer	Bladder or Prostate issues	Headaches	Kidney Disease
Autoimmune disease	Seasonal Allergies	Thyroid Disease	

Other:

Past eye history: Circle any that of these that apply to you:

Eye surgery Laser Eye Surgery Treated with eye drops Treated with Eye Injections

Other eye condition: _____

List any surgeries you have had (eye or body):

_____

_____

Do you have any drug allergies? _____

Do you smoke? YES NO Do you drink alcohol daily? YES NO

Please list any medications that you take: (OK to give a list instead)

Have any of your FAMILY MEMBERS been diagnosed with any of the following? (circle if yes)

Glaucoma Macular Degeneration Retinal Detachment Blindness

Other eye disease: _____