Patient Information

Please bring the receptionist your insurance card and I.D.

Date: _________________Your Primary Medical Doctors Name _______________________________

SS#:________________________Name: ____

Address: ______________________________City___________________State______Zip___________

SEX: ____ Male ____Female Marital Status: ____ Married____ Single ____ Widow____ Divorced

D.O.B.:_____________ Race: _____________Language: _________Phone#_______________________

Cell Phone #:__________________________ Email Address:___________________________________

Employed : Yes ______No ______Occupation:____

Employer: _________________________________ Employer Phone Number: ______________________

Referred By: __________________________________Emergency Contact: _______________________

Spouse Name: ________________________Spouse's DOB: __________Spouse's SS#_______________

Complete if under 18 years of age or a student:

Name of Father: ___________________________________ Fathers DOB: ________________________

Name of Mother: __________________________________ Mother's DOB: _______________________

Insurance Information:

Primary Insurance____

Secondary Insurance____ ____

In case of an emergency:

Name: ____________________________ Relationship to Patient: ______________________________

Address: ____________________________________ Phone Number: _________________________

Pharmacy Information:

Pharmacy Name: _____________________________Street Location_____________________________

Phone #__________________________

Patient's Name: ____

Financial Assignment and Agreement and Release of Information :

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co insurance, or any other balance not paid by insurance.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by insurance.
3. I request that payment of authorized Medicare and/or insurance benefits be made to Dr. Marilu O'Byrne or Dr. Jennifer Moncada on my behalf for any services furnished by us. I authorize any holder of medical information about me to release to the health care financing administration, its agents or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hear by authorize said assignee to release all information necessary to secure the payment.
5. Acknowledgement of Receipt of Privacy Notice: I have been presented with a copy of this practices Notice of privacy policies, detailing how my information may be used and disclosed as permitted under federal and state law.
6. I understand the contents of the notice, and I authorize release of my health information to the following person or persons.
   ____.
   ____
   (List above any person that you want your information given to)

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Signature of Beneficiary, Guardian or Representative   Date

INFORMATION/CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle –closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention. I hear by authorize Dr. O'Byrne and Dr. Moncada and or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

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Patient Signature (or authorized to sign for patient) Date