ANNE ARUNDEL EYE CENTER

Patient Information

Last Name_____First Name_____MI_____

Address_____

City_____State_____Zipcode_____ Marital Status: S M D W

DOB____/____/____ Sex: M / F S.S._____/____/_____ Referred By _____

Daytime Phone □□□-□□□-□□□□ Nighttime Phone □□□-□□□-□□□□

Primary Care Physician_____ Location of PCP_____

We would like to be able to communicate with you via email about your personal patient health information (PHI). Your signature will allow us to email the address you provided with medical information regarding your patient care.

EMAIL: □□□□□□□□□□□□@□□□□□□□□.□□□

Pharmacy _____ Location of Pharmacy _____

Primary Insurance ***Secondary Insurance***

Ins Company_____ Ins Company_____

Policy Holder_____ Policy Holder_____

Relationship_____ D.O.B._____ Relationship_____D.O.B._____

Policy/Member Number_____ _ Policy/Member Number_____

Is this a Workman's Compensation Claim ___ yes ___ no

Patient's Authorization: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, co pays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the provider or designated representative to contact me by telephone or mail about appointments, billing, and medical care. I authorize the physician to release any medical information required to process this claim. I acknowledge that I have been offered a copy of the "Notice of Privacy Practices". **I authorize the disclosure of my protected health information to_____.** A fee for no-shows and record requests may apply.

Emergency Contact_____Relation_____ Emer. Phone_____

Signature of Subscriber or Beneficiary *Date*

*_____ _____