DATE _____

OPHTHALMOLOGY ASSOCIATES
of Western New York, P.C.

PERSONAL INFORMATION

SOCIAL SECURITY NO. _____ – _____ – _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

PATIENT NAME
Last _____ First _____ Middle Initial ____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

MARITAL STATUS: Single _____ Married _____ Divorced _____ Widow _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PH. _____ HOME PH. _____ CELL PH. _____

OCCUPATION _____

EMPLOYER NAME or SCHOOL _____

FULL TIME STUDENT _____ PART TIME STUDENT _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORKPLACE PERSON TO CONTACT _____

SPOUSE'S INFORMATION

SPOUSE'S NAME or GUARDIAN (if patient is under 18 years of age)

Last _____ First _____ Middle Initial ____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

STREET ADDRESS
(Supply ONLY if different from above address) _____

CITY _____ STATE _____ ZIP _____

OCCUPATION _____

EMPLOYER NAME or SCHOOL _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE _____ HOME PHONE _____

EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO PATIENT _____ PHONE _____

CITY _____ STATE _____ ZIP _____

Which of the following influenced the patient to choose our office?

❑ Free Screening ❑ Free Seminar ❑ Doctor Referral ❑ Yellow Pages ❑ Radio ❑ Newspaper ❑ TV ❑ Friend/Relative

List Name of Media or Friend _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS OF HEALTH SERVICES AND REIMBURSEMENT AND PAYMENT OF CLAIMS FROM MY INSURANCE COMPANY. IF FOR ANY REASONS THE ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL BILLING CHARGES, INTEREST CHARGES, COLLECTION COSTS AND REASONABLE LEGAL FEES.

SIGNED DATE