CONSULTING OPHTHALMOLOGISTS, P.C.

Wear now: _____ **C/L**_____ **Glasses**
Need: _____ **C/L** _____ **Glasses**
Eye Surgery _____
Eye Injury _____
Eye Disease _____
Other _____

499 FARMINGTON AVENUE
FARMINGTON, CT 06032
704 HEBRON AVENUE • SUITE 200
GLASTONBURY, CT 06033
(860) 678-0202
Website: www.consultingeye.com

Farmington / Glastonbury
Dr. _____
Date _____
Time _____

Name _____ D.O.B. _____ Sex _____
Last First Middle Initial
Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Bus. Phone ( ) _____ E-mail _____

Soc. Security # _____ Employer _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employed Since _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy Holder _____ D.O.B. _____

Primary Holder's SS # or ID # _____ Group # _____ Employer _____

Secondary Insurance Co. _____ Policy Holder _____ D.O.B. _____

Policy Holder's SS # or ID # _____ Group # _____ Employer _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship_____ Home Phone ( ) _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

REFERRAL INFORMATION

Name of Referring Party _____ Phone ( ) _____

Name of Primary Care Physician_____ Phone ( ) _____

FINANCIALLY RESPONSIBLE PARTY – *Must be completed if patient under 18 or a student.*

Name _____ Relationship _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Bus. Phone ( ) _____ Soc. Security # _____

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to the doctor of any medical benefits otherwise payable to me. I understand I am financially responsible to him for charges not covered by this assignment. I authorize him to release any information requested to support my claim including any information which constitutes a psychiatric communication and/or relates to treatment of alcohol and drug abuse. If any disclosed information contains AIDS/HIV information, state law prohibits further disclosure without specific written consent.

FINANCIAL RESPONSIBILITY
This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default.

SELF-REFERRAL ACKNOWLEDGMENT
I understand that if at any time my insurance plan may not cover my services and I agree to pay all charges.

_____ _____
Signature Date

Office Use Only	Account Number	Dr. Code	DOCTOR	Office Use Only