CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100 704 Hebron Avenue, Suite 200
Farmington, Connecticut 06032 Glastonbury, Connecticut 06033
Office Phone: (860) 678-0202 Fax: (860) 678-0224
www.consultingeye.com

Name_____ D.O.B _____
Last First M.I.

Address_____ City_____ State_____ Zip_____
Phone ( ) _____ Cell Phone ( ) _____ Email_____
Social Security #_____ Employer_____
Employer Address_____ City_____ State_____ Zip_____
Occupation_____ Marital Status: _____Married ___ Single ___Divorced ____Widow
Reason for my visit_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____
Address_____ City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy Holder _____ D.O.B. _____
Primary Holders ID# or SS# _____ Group# _____ Employer_____
Secondary Insurance Co. _____ Policy Holder_____ D.O.B. _____
Primary Holders ID# or SS# _____ Group# _____ Employer_____

REFERRAL INFORMATION

Name of Referring Party_____ Phone ( ) _____
Name of Primary Care Physician _____Phone ( ) _____

FINANCIALLY RESPONSIBLE PARTY- *MUST BE COMPLETED IF PATIENT IS UNDER 18 OR A STUDENT.*

Name _____ Relationship_____ D.O.B._____
Address _____City_____ State_____ Zip_____
Phone ( ) _____ Cell Phone ( ) _____ Social 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 collections. In the event of default, a 15% collection fee will be added to your account if we transfer your account to an outside collection agency.

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

_____ _____
Signature Date

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Patient Name:_____
Last Name First Name Middle Initial

Date of Birth: _____ Birth State:_____

G**ENDER** (**please circle one):** Male Female

PRIMARY LANGUAGE (please circle one):

English Spanish Other (indicate) _____

ETHNICITY (please circle one):
American Indian/Alaskan
Asian
Black/African American
Native Hawaiian
White
Other
Decline to Answer

RACE: (please circle one):
Hispanic or Latino
NOT Hispanic or Latino
Unknown
Decline to Answer

WHY ARE WE ASKING ABOUT RACE, ETHNICITY AND PREFERRED LANGUAGE?

The federal government has required that doctors demonstrate "meaningful use" of their electronic health record by collecting and entering specific demographic data.

We are required to ask Preferred Language, Gender, Race and Ethnicity and Date of Birth. The responses have also been specified by the government; therefore we have listed them on the forms exactly as the government has stated them.

Rationale: Data on disparities of care, especially in areas with a very diverse population and/or specific population health indicators, are critical for the government in its effort to address those disparities and improve the health care system for all Americans. The specific race and ethnicity codes should follow the current federal standards published by the Office of Management and Budget (OMB). Although the rule requires that the listed demographic elements be captured for each unique patient, it is certainly within the patient's right to decline to answer or not know the information. Preferred language captures a patient preference only; there is no requirement for the provider to actually communicate to the patient in that preferred language.

Thank you for assisting us in complying with this mandate.

Signature_____
Date:_____