CONSULTING OPHTHALMOLOGISTS, P.C.

499 Farmington Avenue, Suite 100 | **295 Western Boulevard**
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 Consulting Ophthalmologists, P.C. of any medical benefits otherwise payable to me. I understand that I am financially responsible to the provider for charges not covered by this assignment. I authorize Consulting Ophthalmologists, P.C. to release any information requested to support my claim including information which constitutes a psychiatric communication and/or related 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 fees and cost of collection in the event of a default, a 20% collection fee will be added to your account if we transfer your account to an outside collection agency.
SELF-REFERRAL ACKNOWLEDGEMENT: I understand that if at any time my insurance does not cover my services, I agree to pay all charges.

_________________________________ ________________________
Signature Date