CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100
Farmington, Connecticut 06032
295 Western Boulevard
Glastonbury, Connecticut 06033

Office Phone: (860) 678-0202
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