Patient Information

First Name_____ Last Name_____ MI_____

Date of Birth: _____

Address_____ City_____ Zip_____

Cell Phone: _____ Home Phone:_____

Email_____Occupation_____

Vision Ins.: VBA VSP UPMC VISION CARE(NVA) UPMC VISION ADVANTAGE EYEMED H/Discount

Subscriber's last four digits of SS#:_____Date of birth:_____

Medical Ins._____ Subscriber:_____

Subscriber's ID #:_____Date of birth:_____

Primary Care Physician: _____ Phone#:_____

Please list any medications taken and for what medical reason, including over-the counter meds:

_____

_____

Medical Allergies: _____

Please circle any of the following which you are interested in discussing:

Eyewear Sunglasses Computer glasses Safety glasses Sports Eyewear

Contacts Bifocal contacts Daily Disposable CL Tinted CL Laser Vision Correction

Dry Eye Cataracts Glaucoma Macular Degeneration Diabetic Eye Disease

Amblyopia(Lazy Eye) Strabismus (Crossed Eyes) Keratoconus

Specific topic or problem you would like to discuss: _____

_____

Do you wear Contact Lenses? _____ Please list Brand name, Power and Base Curve(BC)_____

_____

Do you wear Glasses? _____ If so, Please bring them to your office visit.

Patient Name_____ Date:_____

Individual Responsibility for Non –Covered Services

In consideration of services rendered by providers at Csonka Optometric to the undersigned patient, the undersigned promise(s) to pay providers at Csonka Optometric any copayment, co-insurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided. _____ (initial).

Assignment of Benefit Proceeds

I hereby assign to providers at Csonka Optometric all monies and/or benefits to which I am entitled from my insurance/HMO/third party payer, government agencies ,or those who are financially liable for my medical care.

_____(signature) _____ (date).

Authorization to release records

I hereby authorize providers at Csonka Optometric to release my insurer/HMO/third party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by paragraph 1 above, which are not medically necessary or improperly billed.

_____(signature) _____(date)