Date:
Name:
Chart:

Delaware Ophthalmology Consultants

Date of Birth:
Gender: **Male** **Female**
Address**:**

Patient Soc Sec Num
Marital Status: Single
Married
Widowed
Divorced

Primary Phone:
Alternate Phone:(___)__________________
Cell Phone: (___)_________________

Email Address: ___________________________
Patient Employer: _________________________

Please circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*

Preferred Language: English Spanish Other______________________

Race: American Indian Asian Black Native Hawaiian White Multi-racial

Ethnicity: Hispanic Non-Hispanic

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Family Physician: _____________________
Physician Phone: _____________________

Pharmacy: ______________________________
Pharmacy Location/ Phone: ________________

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Primary Insurance:
Insured's Name: _______________________
Insured's Relationship to Pt:______________
Insured's Date of Birth: __________________
Insured's Soc Sec Num: _________________
Insured's Employer: _____________________

Secondary Insurance:
Insured's Name: _________________________
Insured's Relationship to Pt: ________________
Insured's Date of Birth: ____________________
Insured's Soc Sec Num: ___________________
Insured's Employer: _______________________

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PARENT/GURDIAN INFORMATION ***(If patient is under 18 years old or if patient's parent/guardian is the primary insurance holder)***

Name:________________________________
Date of Birth:___________________________
Address:______________________________
____

Social Security Num:________________________
Primary Phone: _____________________________

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NEW PATIENTS ONLY: Whom may we thank for referring you to our office? (Include Name)

Physician _____
Family Member
Phone Book
Website
Current Patient
Other_____

AUTHORIZATIONS

I hereby authorize my examinations, including dilation, during the course of diagnosis and treatment.
I hereby authorize payment directly to Delaware Ophthalmology Consultants for all benefits payable to me under the terms of the insurance policy for treatment of services provided to me or my dependents.
I authorize the release of any medical information necessary to process such insurance claims.
I hereby acknowledge that I have received and had an opportunity to ask questions regarding the Delaware Ophthalmology Consultants' Notice of Patient Privacy Policy.
I hereby authorize that Delaware Ophthalmology Consultants can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes and consent to being enrolled in the e-Prescribe program.
I hereby grant consent for Delaware Ophthalmology Consultants to electronically access my medication history.
I understand that I am financially responsible for any balances or charges not covered by my insurance(s).
I hereby authorize release of medical information and/or faxes regarding my treatment to:
Name of person(s):_____

Signature:_____ Date:____/____/_____