EYE ASSOCIATES OF · LANCASTER · LTD.

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Eye Associates of Lancaster strives to provide our patients with the best possible care. The information requested is needed to help us serve you.

PLEASE RETURN FORMS TO EYE ASSOCIATES AS SOON AS POSSIBLE

☐ Mr ☐ Mrs
Patient's Name : ☐ Ms ☐ Miss _____
(first) (middle) (last)

Address: _____
(street) (apt) (city) (state) (zip)

Home Phone: ( ) _____ Bus Phone: ( ) _____

Date of Birth: _____ Cell Phone: ( ) _____
(month / day / year)

Social Sec #: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Is Patient employed? _____ Student/FT? _____ Student/PT? _____

Employer/School: _____

Employer/School Address: _____

Responsible person/address: (if patient is under 18 yrs old)

_____

EMERGENCY CONTACT PERSON: _____ Relationship to Patient: _____

_____
(Address) (Phone)

Is Patient's condition related to:
Employment? □ Yes □ No Auto Accident? □ Yes □ No Other Accident? □ Yes □ No

Primary Care Physician
Name & Address: _____

Who referred you or how did you hear about Eye Associates? _____

What is your Email address? _____

PLEASE BRING ALL INSURANCE CARDS WITH YOU. THIS INCLUDES YOUR MEDICARE CARD (if applicable) AND ANY OTHER INSURANCE COVERAGE.

Patient's Relationship to Insured:
□ Self □ Spouse □ Child □ Other_____

Insured's Name: _____
(first) (middle) (last)

Insured's Address: _____

_____

Telephone: ( )_____ Insured's Sex: □ Male □ Female

Insured's Date of Birth: _____ Social Sec. # _____

Employer's Name/School: _____

Insured's Insurance Co: _____

Group #_____ I.D. #_____

Is there another Health Benefit Plan? Yes No (If yes, please complete the next section)

OTHER Insured's Name: _____

Insurance Co.: _____

Group #: _____ I.D. #: _____

Employer/School: _____

Date of Birth: _____ Sex: □ Male □ Female

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO EYE ASSOCIATES OF LANCASTER, LTD FOR ANY SERVICES FURNISHED TO ME BY EYE ASSOCIATES (DOCTORS TIEDEKEN, PALANDJIAN, WEI, FILETA, LANDIS, WALKER AND UMARVADIA). I AUTHORIZE ANY HOLDERS OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR ANY OTHER INSURANCE COMPANY THAT I HAVE COVERAGE THROUGH. THIS WOULD PERTAIN TO ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES. I UNDERSTAND THAT CO-PAYMENTS, DEDUCTIBLES, AND ALL CHARGES NOT PAID BY INSURANCE WILL BE THE RESPONSIBILITY OF ME, THE PATIENT.

Signature _____ Date _____

THE OFFICE POLICY…We appreciate payment at the time of service.
Emergency and special situations may be exceptions.