Rosslyn Eye Associates

Patient Information

Name: _____ Age _____
Address: _____
City,State,Zip: _____

Home Phone: _____ Work Phone: _____
Social Security #: _____ Date of Birth: _____
Patient Status: Single: _____ Married: _____ Other: _____
Employed: _____ F/T Student: _____ P/T Student: _____

If Married, Name of Spouse _____

Occupation: _____
Employer Name: _____
Employer Address: _____
_____

Do you participate in any activity which would require safety eyewear? Y N
Do you currently wear contact lenses? Y N
Would you like information about contacts? Y N
How many hours per day do you work at a computer? _____
Who may we thank for referring you? _____

Insurance Information

Name of Insurance: _____
Name of Subscriber: _____
Subscriber ID #: _____ Group #: _____
Subscriber's Employer: _____
Subscriber's Date of Birth: _____

*****PLEASE PROVIDE ALL INSURANCE CARDS AND/OR INFORMATION*****
AT THE TIME OF YOUR EYE EXAMINATION.

**** Due to procedural requirements dictated by insurance companies, we need* ALL *insurance information* BEFORE ANY *services are rendered. We may be* UNABLE *to file for any benefits* AFTER *services have been provided.*

Signature Release:

I authorize Dr. Weiss/Rosslyn Eye Associates, PC to act as my agent for the purpose of obtaining payment of insurance/Medicare benefits. I authorize payment of these benefits to go directly to Dr. Weiss/Rosslyn Eye Associates on my behalf for any services or materials furnished. I authorize any holder of medical information to release that information for the purpose of determining benefits and payment of those benefits and related services. I have been offered a copy of the office privacy policy.

Signature: _____ Date: _____