# Ophthalmic Consultants of Connecticut
## PATIENT INFORMATION FORM

Date: ____________________

Patient's Name: _____________________________ Social Security #: _____ - ______ - __________

Street: ____________________________________ Date of Birth: _______/______/________ Sex __ M ___ F

City: _______________ State: ______ Zip: ________ Marital Status: __ Single __ Married __Divorced __Widowed

Home Phone: (_____) _________________________ Work Phone: (____) _________________________________

Employer: __________________________________

Referring Doctor: ____________________________ Referring Doctor's Phone #: _________________________

Primary Care Physician: _______________________ City, State: _________________________________________

***RESPONSIBLE PARTY*** (if other than patient)

Name: ____________________________________ Home Phone: (_____) _______________________________

Street: ____________________________________ Work Phone: (____) _________________________________

City: _______________ State: ______ Zip: ________ Relationship to Patient: ______________________________

***PRIMARY INSURANCE*** – Please provide us the front and back copy of your insurance ID card

Name of Insurance Company: ___________________ Insured: ____________________________ DOB: ________

Policy #: _______________ Group #: ______________ Relationship to Patient: ____________ SS#: ______________

***SECONDARY INSURANCE*** – Please provide us the front and back copy of your insurance ID card

Name of Insurance Company: ___________________ Insured: ____________________________ DOB: ________

Policy #: _______________ Group #: ______________ Relationship to Patient: ____________ SS#: ______________

I herby authorize *Ophthalmic Consultants of Connecticut* to furnish information concerning my illness and treatment to my insurance carriers.

I authorize payment of medical benefits from all insurance carriers, including Medicare, to *Ophthalmic Consultants of Connecticut*.

I understand that I am responsible for any part of the charges that are not covered by my insurance carriers.

Signed: ____________________________________ Date: ____________________________________________
(Parent or Guardian if patient is a minor)