Pelham Parkway Vision Center

735 Lydig Avenue, Bronx, NY 10462 Tel. (718) 829-2160

Today's date ___/___/___

PATIENT INFORMATION

Patient's Last Name* **First*** **Middle** **Date of Birth*** **Age** **Sex***

_____ _____ _____ ___/___/____ ____ ☐M ☐F

Street Address* **Apt.#** **City*** **State*** **Zip Code***

_____ _____ _____ _____ _____

Home Phone* **Alternative Phone** **Social Security** **Email Address***

(___)____-_____ (___)____-_____ ____-___-_____ _____

Occupation **Employer** **Employer Phone** **Do you wear glasses***

_____ _____ (___)____-_____ ☐ Yes ☐ No

Referred to our office by **How should we contact you***

☐ Friend or Family ☐ Internet ☐ Other_____ ☐ Phone ☐ Email ☐ Mail

Name & Phone of your Primary Care Physician

_____ (___)____-_____

INSURANCE INFORMATION (Please provide receptionist with your insurance card)

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's Name **Subscriber's S.S.#** **Date of Birth** **Sex** **Insurance ID#**

_____ ____-___-_____ ___/___/____ ☐M ☐F _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

_____

Name of Secondary Insurance (if applicable) **Subscriber's Name** **Insurance ID#**

_____ _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Friend or Relative **Relationship to Patient** **Home Phone** **Work Phone**

_____ _____ (___)____-_____ (___)____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pelham Parkway Vision Center or insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: ___/___/_____

I have been presented with a copy of Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand and agree with the contents of the Notice.

I also hereby consent to the disclosure of my health information for the following purposes:

1. To provide my health care treatment;
2. To obtain payment for the services provided to me;
3. To carry out ordinary health care and business operations.

_____ _____

Patient or Legal Representative Signature ***Date***

If not signed by the patient, please indicate relationship to the patient.

_____ _____

Relationship ***Signature of Witness***

For office staff use only

If patient or patient's representative refuses to sign to acknowledgement, document the date notice was presented to the patient and the reason(s) patient or patient's representative refused to sign.

Notice was presented on (date); _____

Signature was not obtained because:_____

_____

Staff Member Presenting the Notice: _____ _____

Name ***Title***

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Date _____

Patient Name _____

I understand that a portion of my comprehensive eye exam will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular disease such as, glaucoma, cataract, etc.)

With the full understanding of the above, I consent to being responsible for co-payments, coinsurance and/or deductable.

_____

Patient's signature