BURLINGTON COUNTY
EYE PHYSICIANS

PATIENT INFORMATION FORM

Thank you for choosing the Burlington County Eye Physicians.
We are participating in the government's Meaningful Use Requirements Program, which is intended to improve care coordination and ensure security and privacy provisions for personal health information. Please complete this form so we have accurate information about you.

Name:_____ Date of Birth:_____/_____/_____ Gender: M ☐ F ☐

Address _____ City_____State _____

Zip Code _____ Social Security _____-_____-_____

Phone #'s: (H) _____-_____-_____ (W) _____-_____-_____ (C) _____-_____-_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family Doctor: _____ Phone Number: _____

Referring Doctor: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Pharm Name/City: _____ Pharm Phone# _____

Email Address:_____

Smoking Status:

☐ Current, everyday smoker ☐ Current, part-time smoker ☐ Former smoker

☐ Never smoked ☐ Current status unknown ☐ Unknown if ever smoked

Race:

☐ White ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Decline to Answer

Ethnicity:

☐ NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Answer

Preferred Language: _____

Height: _____Ft _____Inches Weight: _____ Blood Pressure _____/_____

Additional Data:

☐ HIV ☐ MRSA ☐ HEP A ☐ HEP B ☐ HEP C

Please hand your insurance cards to the receptionist with this form.

If you are not the subscriber for your insurance, please provide:

Subscriber Name_____ DOB _____/_____/_____

Subscriber SS# _____-_____-_____ Relationship to Patient _____

If this is a Worker's Compensation Exam, please provide Employer information:

Employer Name _____ Occupation _____

Address _____ City, State, Zip _____

Contact Phone (_____)_____ ext_____

Telephone Consumer Protection Act (TCPA)

I/we agree in order for Burlington County Eye Physicians, its employees, and/or agents to service our account or to collect monies I may owe that they may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in additional charges. I understand method of contact may include text messages, emails (using any email address I have provided) in the form of pre-recorded/artificial voice messages and/or use of automatic dialing as applicable. I have read this disclosure and agree that Burlington County Eye Physicians, its employees and/or agents may contact me/us as described above.

Insurance Authorization and Assignment

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to Burlington County Eye Physicians.

Agreement to Pay

I understand that I am financially responsible for charges not covered by assignment, co-insurance charge, deductibles, and non-covered services.

Patient's signature_____ Date_____

(Signature of insured or authorized agent, patient, or parent if minor)

How did you hear about us? (please "x" one)

_____ Phone Book
_____ Church Bulletin
_____ South Jersey Magazine
_____ SJ Magazine
_____ Friend/Relative: _____
_____ Internet- Search Engine (Google, Yahoo, Bing, etc)
_____ Internet- Facebook
_____ Internet- Twitter
_____ Internet- Instagram
_____ Other: _____