WELCOME TO YORK EYE ASSOCIATES, P.C.

Please Print

PATIENT INFORMATION: **DATE:** ________________

Patient Name: ____
Address: ____
City/State/Zip: ____
Home Phone: ( ) ______________________ Mobile Phone: ( ) ______________________
Work Phone: ( ) ______________________ Email: ______________________
Gender: M____ F____ Date of Birth: ____________ Age: ________ Marital Status: ____________
Social Security #: ______________________ Driver's License #: ______________________

Employed By: ______________________ Occupation: ______________________
Spouse's Name: ______________________ Work Phone: ( ) ______________________
Parent or Legal Guardian: ____
Address: ____
City/State/Zip: ____
Home Phone: ( ) ______________ Mobile Phone: ( ) ______________ Work Phone: ( ) ______________

Primary Care Physician: ______________________ **Phone Number:** ______________________
Address: ____

Electronic Health Record Required Questions:
Primary Language: (check one)
( )English ( )Spanish ( )Other: __________ ( )Decline to Answer
Race: (check one)
( )Caucasian ( )African American ( )Asian ( )Hispanic/Latino ( )Native American ( )Other ( )Decline to Answer
Ethnicity: (check one)
( )Not Hispanic or Latino ( )Hispanic or Latino ( )Unknown ( )Decline to Answer
Vitals: Height: ___ft ___in Weight: ____ lbs ( )Decline to Answer

INSURANCE INFORMATION

VISION INSURANCE: __ No __ Yes If yes, name of vision insurance: ______________________
Insured's Name: ______________________ Insured's DOB: ______________________
Insurance ID #: ______________________ Group #: ______________________
MEDICAL INSURANCE: __ No __ Yes If yes, name of vision insurance: ______________________
Insured's Name: ______________________ Insured's DOB: ______________________
Insurance ID #: ______________________ Group #: ______________________

Who is responsible for payment if not covered by insurance? ______________________
Address if different from above: ______________________

We file all Medicare/Medicaid claims and most other insurance plans; but due to the large number of ins. plans we participate in, knowledge of any special plan requirements or limitations is your responsibility.

ALL PATIENTS MUST READ THE FOLLOWING STATEMENTS AND SIGN BELOW

I, the undersigned, certify that I (or my dependents) have insurance coverage. I assign all payments to York Eye Associates, P.C. and their doctors for services rendered. I authorize the release of any medical information necessary to process this or any future claims. I understand that any unpaid patient balance after 30 days will begin acquiring a monthly finance charge of 1.5%.

By my signature, I acknowledge that I have read and understand the above statements.
Patient Signature: ____________________________________ Date: ______________________
(or responsible party)