



# Digby Eye Associates

## Patient Information Form

Name \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male / Female \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_ Home Telephone \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Employed: Fulltime / Part-time Student: Fulltime / Part-time Email address \_\_\_\_\_

Name of Spouse \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse Employer \_\_\_\_\_ Spouse Work Telephone \_\_\_\_\_

Referring Source: Family \_\_ Friend \_\_ Ins. \_\_ Yellow Pages \_\_ TV \_\_ Radio \_\_ Other Ad \_\_ MD \_\_ OD \_\_

Referred by MD or OD – Complete Name \_\_\_\_\_

Contact in case of emergency: Name \_\_\_\_\_ Phone \_\_\_\_\_

---

### Self pay and patients with insurance, please complete and sign below

Please let us make a copy of your insurance card(s)

Primary Insurance Carrier \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_

Is this plan through an employer? No / Yes Employer \_\_\_\_\_ Self/Spouse/Parent

Parent Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I hereby authorize release of any information necessary to process this claim and request that payments of benefits be made either to myself or to the party who accepts assignment. I understand that I am financially responsible for all charges not paid by said insurance. A copy of this authorization will remain on file for all future treatment. I authorize said assignee to release all information to secure payment.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

---

Is your visit with us today due to a work related injury? Yes / No

If yes, please provide the following information:

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisor's Name \_\_\_\_\_