



Ophthalmology & Optometry

**PATIENT INFORMATION**

**NAME:** \_\_\_\_\_ **Gender:** Male Female

**HOME ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**PHONE NUMBERS:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**Home:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Work:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Cell:** \_\_\_\_\_ **MARITAL STATUS:** M D S W O

If minor child – Patient/ Legal Guardian: \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_

Name & Address of Employer \_\_\_\_\_

**PRIMARY INSURANCE**

**PLAN:** \_\_\_\_\_

**SUBSCRIBER ID:** \_\_\_\_\_

**GROUP:** \_\_\_\_\_

**SUBSCRIBER'S NAME & BIRTHDATE:** \_\_\_\_\_

**SECONDARY INSURANCE**

**PLAN:** \_\_\_\_\_

**SUBSCRIBER ID:** \_\_\_\_\_

**GROUP:** \_\_\_\_\_

**SUBSCRIBER'S NAME & BIRTHDATE:** \_\_\_\_\_

I consent to treatment necessary for the care of the above names patient. I authorize the release of all medical records to the referring and family physicians to my insurance company, if applicable. I will allow fax transmittal of my medical records if necessary. I acknowledge full financial responsibility for services rendered to **JAY C. GROCHMAL, M.D. and Associates**, and authorize transfer of all unpaid amounts to my Visa/MC or other credit card by phone 120 days from the date of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my account. I further authorize and request that all insurance payments be made directly to JAY C. GROCHMAL, M.D., P.A.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_