DELAWARE
OPHTHALMOLOGY
CONSULTANTS

Date:

Name:

Chart #:

Delaware Ophthalmology Consultants

Date of Birth: Patient SSN:

Gender: __ Male __ Female __ LGBTQIA+ Marital Status:

Address : __ Single

__ Married
__ Widowed

__ Divorced

Primary Phone: (___)_____

Alternate Phone:(___)_____ Email Address:

Cell Phone: (___)_____ Patient : Employer:

_____ _____

Please circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*

Ethnicity: Hispanic American Indian Asian Black
Native Hawaiian White Multi-racial

Preferred Language: English Spanish Other_____

Family Physician: _____

Physician's phone:_____

Pharmacy: _____

Pharmacy phone:_____

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Primary Insurance:_____ Secondary Insurance:_____

Insured's Name: _____ Insured's Relationship:_____

Insured's Date of Birth:_____ Insured's SSN:_____

Insured's Employer: _____ Insurance #:_____
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PARENT/GUARDIAN INFORMATION ***(If patient is under 18 years old or if patient's parent/ guardian is the primary insurance holder)***

Name:_____ SSN:_____

Chart #:_____

Date of Birth:_____ Primary Phone: _____

Address:_____

NEW PATIENTS ONLY: Whom may we thank for referring you to our office? (Include Name)

__ Physician _____
__ Family Member_____
__ Phone Book
__ Website
__ Current Patient_____
__ Other_____

AUTHORIZATIONS

I hereby authorize my examinations, including dilation, during the course of diagnosis and treatment.
I hereby authorize payment directly to Delaware Ophthalmology Consultants for all benefits payable to me under the terms of the insurance policy for treatment of services provided to me or my dependents.
I authorize the release of any medical information necessary to process such insurance claims.
I hereby acknowledge that I have received and had an opportunity to ask questions regarding the Delaware Ophthalmology Consultants' Notice of Patient Privacy Policy.
I hereby authorize Delaware Ophthalmology Consultants to create an account on a secure web server for the purposes of my accessing my medical history and account information accessible only by myself or my proxy.
I hereby authorize that Delaware Ophthalmology Consultants can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes and consent to being enrolled in the e-Prescribe program.
I hereby grant consent for Delaware Ophthalmology Consultants to electronically access my medication history.
I understand that I am financially responsible for any balances or charges not covered by my insurance(s).
I hereby authorize release of medical information and/or faxes regarding my treatment to:
Name of person(s):_____

Signature:_____ Date:____/____/_____