



Patient Information



Thank you so much for choosing Eye Physicians & Surgeons of Bucks County.

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: _____ Referring Doctor: _____

Pharm Name/City _____ Pharm Phone# _____

Do you have internet access? YES NO Email Address: _____

Smoking Status:

Current, every day smoker Current, part-time smoker Former smoker 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

Ethnicity:

NOT Hispanic or Latino Hispanic or Latino

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 _____

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

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)

- | | |
|--|--|
| <input type="checkbox"/> Phone Book | <input type="checkbox"/> Website, www.bceye.com |
| <input type="checkbox"/> Church Bulletin | <input type="checkbox"/> Bingo Program |
| <input type="checkbox"/> South Jersey Magazine | <input type="checkbox"/> Burlington County Woman Publication |
| <input type="checkbox"/> SJ Magazine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Friend/Relative _____ | |

Please provide your friend/relative's name so we can thank them for referring you to us 😊



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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

_____ Website, www.buckscountyeyephysicians.com

_____ Other: _____

_____ Friend/Relative _____

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