PATIENT INFORMATION					
NAME (Last, First)	MIDDLE NAME	SSN#	BIRTH DATE	LANGUAGE	SEX
ADDRESS	CITY, STATE, ZIP	MARITAL STATUS	ETHNICITY	CURRENT GENDER	
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS			
REFERRING PHYSICIAN	TEL#				
PRIMARY CARE PHYSICIAN	TEL#	PHARMACY	ADDRESS, TEL #		

EMPLOYER	WORK PHONE
ADDRESS	CITY, STATE ZIP

EMERGENCY CONTACT				
NAME (Last, First, Middle)		BIRTH DATE	LANGUAGE	SEX
ADDRESS	CITY, STATE, ZIP	PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE	
NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#

SECONDARY INSURANCE (If Applicable)	
NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#

I authorize Connecticut Eye Consultants to disclose/discuss my protected health information with:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I, the undersigned, authorize Connecticut Eye Consultants, PC to bill my insurance company for services rendered, and to release information as requested by the insurance in order to process my bill. I understand **I AM RESPONSIBLE FOR OBTAINING A REFERRAL IF REQUIRED BY MY INSURANCE. I UNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH NON-COVERED CHARGES, DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY INSURANCE PLAN**. I acknowledge full responsibility for all balances including no-show fees and fees incurred by Connecticut Eye Consultants in an attempt to collect those balances.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE