Glen Ellyn Ophthalmology Associates, LTD

Patient Information

Patient's Name:		Sex: **M / F**	Age:	Date of Birth:	
Home Address:		Social Security #:	**XXX-XX-_ _ _ _**		
		Occupation:			
		Is today's visit due to an accident?	**Y / N**		

PLEASE CIRCLE **the best number for appointment reminders** →	What is your **HOME** phone #?	What is your **WORK** phone #?	What is your **Cell** phone #?

Employer Name: _____

Work Address: _____
Street City State Zip

Patient Privacy

Do you object to us sharing or discussing your health information with your family, friends or others involved in your care or for payment for your care?

_____ I **DO NOT** object _____ I **DO** object

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____

Phone Numbers: _____
Home Work Cell

Financial Guarantor Information

(Who carries the insurance or is responsible for payment of the patient's bill?)

Guarantor Name: _____ Relationship to Patient: _____
First MI Last

Address: _____ Date of Birth: _____
Street

_____ Social Security #: _____
City State Zip

Phone Numbers: _____
Home Work Cell

Employer Name: _____

Work Address: _____
Street City State Zip

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Glen Ellyn Ophthalmology Associates, LTD

Assignment of Benefits, Release of Information, Receipt of Privacy Policy, and Consent to Treatment

Assignment of Benefits:

I request that payment of an authorized insurance and/or Medicare of Medicaid benefits be made on my behalf to Glen Ellyn Ophthalmology Associates, Ltd.

Release of Information:

I authorize the release of my medical information, including my diagnosis, records of any examination or treatment, and/or records of charges for services rendered to other doctors, hospitals or insurance companies concerned in my care and treatment. This release will be valid until I notify you otherwise in writing.

Consent to Treatment:

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in her or her medical judgment.

Privacy Policy:

I have received a copy of the privacy policy for Glen Ellyn Ophthalmology Associates, Ltd.

My signature below confirms that I have read the *Assignment of Benefits, Release of Information, Receipt of Privacy Policy, and Consent to Treatment* and agree with its terms and conditions. It will remain in effect until revoked by me in writing. I consider an image of this document scanned into my medical record as valid as an original.

_____ _____

Patient's Signature (or Parent/Guardian) Date