Ophthalmology
Collegeville Eye Physicians & Surgeons

Ophthalmology
Physicians & Surgeons, PC

Eye Care
Physicians & Surgeons

Patient Name: _____ _____ _____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Work#: _____

Is it OK to leave you a detailed message? ON: Home phone: ❑ Yes ❑ No **Cell phone:** ❑ Yes ❑ No

Social Security Number: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Spouse/Parent Name: _____

Email address: _____ Preferred Contact Method: ❑ Home ❑ Cell ❑ Work

Emergency Contact Name: _____ Phone #: _____

Race: ❑ American Indian ❑ Asian ❑ Black ❑ Pacific Islander ❑ White ❑ Other Ethnicity: ❑ Hispanic ❑ Non-Hispanic MY

SPECIALISTS (Doctor, not group name):

Rheumatologist: _____ Endocrinologist: _____

Oncologist: _____ Other Specialist: _____

INSURANCE INFORMATION:

Do you have Medical Insurance? ❑ Yes ❑ No Do you have a Vision Plan/Insurance? ❑ Yes ❑ No

Is this Worker's Compensation? ❑ Yes ❑ No Is this an Accident? ❑ Yes ❑ No

PERSON RESPONSIBLE FOR PAYMENT (if the patient is a minor, please complete with information for a parent or guardian responsible for payment):

Name: _____ Address: _____

Phone: _____ Social Security Number: _____ DOB: _____

Relationship To Patient: _____

I hereby authorize Ophthalmology Physicians & Surgeons to provide treatment and services to myself and/or the above named patient. I also authorize the release for any and all necessary information to my insurance carrier(s) for direct processing to Ophthalmology Physicians & Surgeons. Payment is expected at the time of visit unless alternative arrangements have been made prior to your visit. Patients are responsible for the payments of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of your appointment. For your convenience, we accept cash, check, and most major credit cards at our office. I also understand that if I do not show up for my appointment or provide **24 hours advance notice that I am unable to keep that appointment, I will be charged a $50.00 no-show fee for a Monday-Friday cancellation or a $75.00 no-show fee for a Saturday cancellation, and a $100.00 interpretation involved cancellation fee.** By my signature below, I hereby authorize assignment of financial benefits directly to OPS and any associated healthcare entities for services rendered as allowable under standard third party contracts.

_____ _____
Patient's signature **Today's date**

Bethlehem
65 E. Elizabeth Avenue
Suite 300
610-868-0130
(F) 610-868-0612

Blue Bell
1179 DeKalb Pike
2nd Floor
610-272-1211
(F) 610-272-3858

Collegeville
753 West Main Street
Suite D
610-489-7440
(F) 610-489-7130

Hatboro
331 North York Road
Building A
215-672-4300
(F) 215-672-9524

Levittown
1609 Woodbourne Road
Suite 303
215-547-1818
(F) 215-547-5174

North Wales
1140 Welsh Road
Suite 220
215-542-1522
(F) 215-542-9609