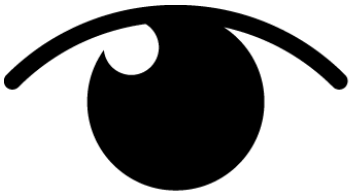

OPHTHALMIC CONSULTANTS of the Capital Region

PATIENT INFORMATION:

Title: _____ Last: _____ First: _____ MI:_____

Address:_____ City:_____ State:_____

Zip:_____ Home #:_____-_____-_____ Cell #: _____-_____-_____ Work #: _____-_____-____

Social Security #: _____-_____-_____ Sex (Circle One): Male Female DOB: _____/_____/_____

Driver's License #: _____-_____-_____ Preferred Language: _____

Marital Status: _____ Race/ Ethnic Identity: _____

Email Address: _____ Preferred Contact method: □ Home □ Cell □ Work □ Email

Primary Care Doctor: _____

Emergency Contact Name: _____ Phone: _____-_____-_____

MY SPECIALISTS:

Rheumatologist: _____ Endocrinologist: _____

Oncologist: _____ Other Specialist(s):_____

INSURANCE INFORMATION:

Do you have Medical Insurance? [ ] YES [ ] NO

Do you have a vision plan/insurance? [ ] YES [ ] NO

Is this a Worker's Compensation? [ ] YES [ ] NO

Is this No Fault? [ ] 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 #: _____-_____-_____ DOB: _____/_____/_____

Relationship to patient: _____

I hereby authorize Ophthalmic Consultants of the Capital Region 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 Albany- Troy Cataract & Laser Associates, PLLC (dba) Ophthalmic Consultants of the Capital Region. Payment is expected at the time of visit unless alternative arrangements have been made prior to your visit.

Signature: _____ Date: _____/_____/_____