

# Welcome to our practice



Date \_\_\_\_\_ CEA Assigned Account Number \_\_\_\_\_

Name \_\_\_\_\_ Nick Name \_\_\_\_\_  
EXACTLY AS IT APPEARS ON YOUR INSURANCE CARD

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Check Appropriate Boxes:  Male  Female  Single  Married  Divorced  Widowed

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
NECESSARY FOR SCHEDULING SURGICAL PROCEDURES NOT PERFORMED IN THE OFFICE

Referring Physician \_\_\_\_\_ Referring Physician's Office Number \_\_\_\_\_

If not referred by your physician, how did you find out about us:

Friend  Family  Other (please specify) \_\_\_\_\_

Yellow Pages  Radio  Coupon  Insurance Company  Website

Primary Care Physician \_\_\_\_\_ PCP's Office Phone \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Contact's Phone \_\_\_\_\_

## Insurance Information:

Primary Insurance \_\_\_\_\_ Contract Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Contract Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Please note that all fees and co-payments are due at the time of your visit including payment in full for contacts or glasses. We accept cash, personal checks or you may pay by credit card. If you pay by check and it is returned for any reason, you will be charged a \$25 service charge.

I assign all medical/surgical benefits to Cornerstone Eye Associates for services performed by or optical goods purchased through Cornerstone Eye Associates staff and authorize the release of information concerning my care to the health insurance company listed above.

I understand and agree that, regardless of the status of my insurance, I am ultimately responsible for the balance on my account. If any amount due for services or products is not paid within 60 days of the initial charge, the responsible party agrees to pay all costs for collecting or attempting to collect payment of the amount due.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY (Must be 18 years or older)

\_\_\_\_\_  
DATE