Welcome to our practice



Cornerstone
Eye Associates

www.cornerstoneeye.com

Date_____

Patient Name_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____ Pharmacy Name/Location_____

Check Appropriate Boxes: ❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Date of Birth_____ Social Security Number_____

Referring Physician_____ Referring Physician's Office Number_____

If not referrred 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

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