ROCHESTER REGIONAL HEALTH | **Rochester Regional Health**
Reed Eye Associates

----- Patient Demographics -----

Welcome to Our Practice

PATIENT INFORMATION

Full Name: _____ Birth Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____ Email Address: _____

Check Appropriate Boxes ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Employer: _____ Occupation: _____ Work Phone: _____

Spouse's Name: _____ Employer: _____ Work Phone: _____

Preferred Pharmacy and Location: _____

INSURANCE INFORMATION

Primary Insurance: _____ Contract #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Secondary Insurance: _____ Contract #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Primary Care Physician: _____ Referring Physician (if different): _____

For patients under 19, or if you are covered under parent's insurance

Father's Name: _____

Employer: _____ Work Phone: _____

Mother's Name: _____

Employer: _____ Work Phone: _____

Please note that all fees and copayments are due at the time of your visit and can be paid by cash, check or credit card. If you pay by check and it is returned for any reason, you will be charged a $15.00 service charge.

RELEASE OF INFORMATION

I assign all medical/surgical benefits to Reed Eye Associates of services performed by Reed Eye Associates staff and authorize the release of information concerning my care to the health insurance agency listed above.

I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection that I will be responsible for all fees and expenses incurred by any collection agency or attorney.

SIGNED: _____ **Date:** _____

Patient / Guardian / Responsible Individual – must be 18 or older to sign