PARAGON OPHTHALMOLOGY

Patient Chart Number:

Last Name	First Name	MI	Gender	Birth Date
Address		City	State	Zip Code
Primary Phone	Work Phone	Secondary Phone	SSN	
Email Address		Referring Physician/Family Physician		
Emergency Contact:		Phone:		
Relationship:				

RESPONSIBLE PARTY INFORMATION

Last Name	First Name	MI	Birth Date	Gender
Address	City	State	Zip Code	Relationship
Primary Phone	Work Phone		SSN # <P86>	

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name		Insurance Name	
Claims Address		Claims Address	
Subscriber's Name		Subscriber's Name	
Subscriber ID	Group No.	Subscriber ID	Group No.
Subscriber SSN	Subscriber Birth Date	Subscriber SSN	Subscriber Birth Date

I hereby authorize Paragon Ophthalmology to examine and treat my child or me and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury/illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy be paid directly to Paragon Ophthalmology. I understand that this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders and/or HIV serostatus. I understand that I am responsible for the fees for all services rendered (and equipment/supplies provided) to my child or me. I guarantee payment of the portion of my account for which I am responsible at the time of service or within the pre-arranged time frame agreed upon by the business office. I agree that, in the event I default and do not pay my balance, reasonable costs of collection, and/or reasonable attorney fees may be added to the amount due on the account and I agree to be financially responsible for those additional charges.

Signature of Patient/Responsible Party _____ _____

Dated _____