CROSSROADS EYE PHYSICIANS

Marc A. Honig M.D. **Lee A. Snyder M.D.** **Gary H. Cassel M.D.**
Sherry Higginbotham O.D. **Steven L. Pinson O.D.**
23 Crossroads Drive Owings Mills, Maryland 21117 410-581-1500

Patient Name First Middle Last				Date of Birth	Age
Home Address No. Apt.	City	State	Zip Code	Your Home Phone	
Occupation Employed (circle one) Retired Student	Social Security No.	Marital Status (circle one) S M D W		Sex	Your Mobile Phone
Employer (or previous employer, if retired)	Address			Your Work Phone	
Spouse (or Parent) Name	Spouse Employer	Phone		Your Email Address	
Nearest Relative/Friend	Relationship	Phone			
Primary Care Physician	Address			Phone	

Policy Concerning Payment of Medical Bills

Our policy is payment of any copays (or noncovered services) is to be made at the time services are rendered unless prior arrangements have been made. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier.

If your insurance plan is an HMO which requires a referral, you will be responsible for payment if no referral is provided at time of the visit.

I agree to promptly pay all charges for medical services rendered and accept legal responsibility for all charges for the patient named above.

X _____

Billing and Insurance Information

SEND BILL TO:	First Name Last Name			Relationship To Patient
	Home Address		City	State
	Employer		Work Phone	Home Phone
INS. INFO	Policy Holder's Name	Sex	Policyholder's Social Security No.	Policyholder's Relationship to Patient
	Insurance Company	Employer	Policyholder's Work Phone	Policy Holder's Date of Birth

A valid insurance card with the patient's name and ID# must be presented at the time of the visit for this office to file for insurance payment. If the insurance card is for a dependent of the policy holder, the employer's name, SS #, DOB, and work phone # of the policy holder is required.

Patient Authorization

I, _____, hereby authorize my provider at Crossroads Eye Physicians to apply for benefits on my behalf for covered services rendered. I request payment from, Medicare, Blue Shield of Maryland, and/or _____ insurance company, be made directly to the above-named provider or the party who accepts assignment.

I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including information to this or any related claim, to the above-named billing agent, Centers for Medicare and Medicaid Services, and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

_____ _____

Date Signature of Subscriber or Beneficiary

Account Number

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GENERAL MEDICAL HISTORY

NAME: _____ **DOB:** _____

MEDICATIONS TAKEN ON REGULAR BASIS: _____

_____

_____

PREFERRED PHARMACY:

Name _____

Address _____

Phone _____

KNOWN DRUG ALLERGIES: _____

PAST SURGERIES AND HOSPITALIZATIONS: _____

_____

SERIOUS INJURIES: _____

****

Do you have?

___Diabetes
___Heart Disease
___High Blood Pressure
___Arthritis
___Thyroid Disease
___Migraine Headaches
___Seizures
___Other _____

List Any Relative Who Has Had:

Cataracts _____
Glaucoma _____
Diabetes _____
Lazy Eye _____
Other _____

Past Ocular History:

___Glaucoma
___Cataracts
___Eye Injury
___Retinal Disease
___Eye Surgery
___Laser Surgery of Eye

Do You Currently Wear?

___Reading Glasses
___Distance Glasses
___Bifocals
___Contact Lenses

Account Number