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		

The following data is collected and used to track quality of care. This information is kept confidential and goes directly into your medical record.

Language
☐ English
☐ Spanish
☐ Other_____

Race
☐ White
☐ Asian
☐ Other _____
☐ American Indian or Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Black/African American

Hispanic/Latino
☐ Yes
☐ No

RESPONSIBLE PARTY INFORMATION

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

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

EMERGENCY CONTACT

Name **Phone** **Relationship**

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 _____