PATIENT INFORMATION FORM

Hudson Valley Eye Surgeons, P.C.
Vassar Brothers Medical Mall
200 Westage Business Center Drive
Fishkill, NY 12524
Phone: 845-896-9280
Fax: 845-896-0246

PATIENT'S INFORMATION:

May We Email You News about Our Practice? Yes☐ No☐
(Permission Required)

Email Address: ______________@_________._____

Name: _______________ _______ ________________
First Middle Last

Gender: Male ☐ Female ☐

Date of Birth _____/_____/__________
Address: ______________________________
City ______________ **State** _____ **Zip** ________
Social Security Number: _____—_____—______
Primary Care Physician name: ______________
Preferred Language: _____________

		Call At	Text At
Home phone	______-______-______	☐	☐
Work phone	______-______-______	☐	☐
Cell phone	______-______-______	☐	☐

Ethnicity: ☐ **Hispanic/Latino** ☐**Non Hispanic/Latino** ☐**Declined** **Race: ___________** ☐ **Declined**

Who sent you to us today? ______________________________________

	Primary Coverage	**Secondary Coverage**
Insurance Company	________________________	________________________
Insurance ID#	________________________	________________________
Group name or #	________________________	________________________
Co-pay amount	________________________	________________________
Name of Insured	________________________	________________________
Patient's relationship to insured	________________________	________________________
Insured's Employer	________________________	________________________
Address	________________________	________________________
Insured's Date of Birth	________________________	________________________

If Patient is a Minor, please fill in information for Guardian Responsible for Bill:
Social Security Number: _____—_____—_____
Name: ______________ ___________ _________________ Daytime phone (_____) _____-______
First Middle Last Home phone (_____) _____-______
Address: ____________ City ____________ State _____ Zip _______

Person to contact in case of emergency:
Name: __________________ Cell phone (_____) _____-______ Home phone (_____) _____-______

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: ____ Date: ______________________________

I authorize the release of any medical information necessary to process this claim and authorize payment of benefits either to myself or the party who accepts assignment or the physician supplier listed below.

Signature: ____ Date: ______________________________

Turn Over for Dilation Consent Form