



TRI·COUNTY

Eye Physicians & Surgeons, PC
www.tricountyeye.com

319 Second Street Pike · Southampton PA 18966 • 215.355.4428
352 E Butler Ave (Rt 202) · New Britain PA 18901 • 215.230.4700

Name	Record#
Address	
DOB	

Patient Information Record

_____	_____	_____	_____	_____	_____	_____
Last Name	First Name	Initial	Mr. Mrs. Ms.	Today's Date	Birth Date	Age
_____	_____	_____	_____	_____	_____	_____
Address				Home Phone	Work Phone	
_____	_____	_____	_____	_____	_____	_____
City	State	Zip	Occupation		Employer	
_____	_____	_____	_____		_____	
Social Security #	If married, Spouse's Name		E-mail Address			

Primary Insurance Coverage:

_____	_____	_____	_____
Type / Plan Name	Policy / ID Number	Subscriber name	Relationship

Secondary Insurance Coverage:

_____	_____	_____	_____
Type / Plan Name	Policy / ID Number	Subscriber name	Relationship

Lifetime Signature / Authorization:

I request that payment of any and all authorized Insurance benefits be made either to me on my behalf or to Tri-County Eye Physicians & Surgeons, PC for professional services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	_____	_____	_____
Name of Insured	Social Security Number	Patient's Signature	Date

Referral Information:

_____	_____	_____	_____
Family Physician	Practice Name / Location	Optometrist	Office Location

Medical History

_____	_____	_____
Reason for Today's Examination	Date of Last Eye Exam	Previous Eye Doctor
_____	_____	_____
Current Medical Condition(s)	Age of Present Glasses	
_____	_____	
Current Medications (pills, drops, ointments)	Medication Allergies	

Additional Information from Medicare patients only:

Do you or your spouse work? Yes _____ No _____

If yes, does employer provide you with health insurance? Yes _____ No _____

Are you entitled to Medicare because of end-stage renal disease, motor vehicle accident, Federal Black lung disease or another injury? Yes _____ No _____

If you answered YES to any of the above questions:

What company / agency provides you with health insurance? _____

Name of Insurance Company _____ Your Insurance ID # _____

Medicare Extended Authorization / Lifetime "Signature on File:"

I request that payment of any and all authorized Medicare benefits be made either to me on my behalf or to Tri-County Eye Physicians & Surgeons, PC for professional services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	_____	_____	_____
Name of Insured	Social Security No.	Patient's Signature	Date
_____	_____	_____	_____
Name of Insured	Social Security No.	Patient's Signature	Date
_____	_____	_____	_____
Name of Insured	Social Security No.	Patient's Signature	Date
_____	_____	_____	_____
Name of Insured	Social Security No.	Patient's Signature	Date

Medigap Assignment of Benefits:

I request that payment of any and all authorized Medigap benefits be made either to me on my behalf or to Tri-County Eye Physicians & Surgeons, PC for professional services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	_____	
Medigap Insurance Carrier	Medigap Insurance Policy No.	
_____	_____	
Beneficiary Name	Patient's Signature	Date

Please show your insurance card(s) to the receptionist!