JAY C. GROCHMAL, M.D., P.A.

Ophthalmology & Optometry

PATIENT INFORMATION

NAME: _____ **Gender**: Male Female

HOME ADDRESS: _____

CITY: _____ **STATE**:_____ **ZIP CODE**: _____

PHONE NUMBERS: **DATE OF BIRTH**: _____

Home: _____ **Age**: _____ E-mail_____

Work: _____ **Social Security #** _____-_____-_____

Cell: _____ **MARITAL STATUS**: M D S W O

Race:_____ Primary Language:_____ Ethnicity:_____

If minor child – Patient/ Legal Guardian: _____

OCCUPATION: _____

Name & Address of Employer _____

PRIMARY INSURANCE

PLAN: _____

SUBSCRIBER ID: _____

GROUP: _____

SUBSCRIBER'S NAME & BIRTHDATE: _____

SECONDARY INSURANCE

PLAN: _____

SUBSCRIBER ID: _____

GROUP: _____

SUBSCRIBER'S NAME & BIRTHDATE: _____

I consent to treatment necessary for the care of the above names patient. I authorize the release of all medical records to the referring and family physicians to my insurance company, if applicable. I will allow fax transmittal of my medical records if necessary. I acknowledge full financial responsibility for services rendered to **JAY C. GROCHMAL, M.D. and Associates,** and authorize transfer of all unpaid amounts to my Visa/MC or other credit card by phone 120 days from the date of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my account. I further authorize and request that all insurance payments be made directly to JAY C. GROCHMAL, M.D., P.A.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE: _____ DATE: _____