

MEDICATIONS Please List Prescription and Over-the-Counter Medications, Vitamins, Herbs, Supplements and Eye Drops:

Names of Medications, Supplements and Drops	Taken For What Condition?

FAMILY HISTORY Parent, Grandparent, Brother or Sister has/had any of the following?
 Glaucoma Cataracts Macular Degeneration Retinal Problem
 Blindness Diabetes Other _____

INSURANCE INFORMATION

*Note: Insurance Carriers Cannot Be Named As Responsible Parties

Person Responsible for Account _____
 Relation to Patient _____ Birth Date _____ S.S.# _____
 Address (if different from patient's) _____
 City _____ State _____ Zip _____ Phone _____
 Person Responsible Employed by: _____
 Business Address _____ Busn. Phone _____
 Insurance Company _____
 Subscriber I.D.# _____ Group # _____

AUTHORIZATIONS

I, the undersigned, have insurance coverage with _____
 (Name of Insurance Company)
 and assign directly to Mechanicsburg Eye Associates all medical/vision benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance claims submissions.

_____ Date _____
 Signature of Patient/Guardian