PATIENT INFORMATION **CHRIS M. PETRAS, M.D.**

NAME OF PATIENT _____ BIRTH DATE _____AGE _____

FIRST M. LAST MO/DAY/YR

ADDRESS _____

STREET CITY STATE ZIP

HOME # _____ CELL #_____ WORK # _____ PREFFERED # _____

EMAIL_____ SOCIAL SECURITY # _____

OCCUPATION _____ EMPLOYED BY _____

MARITAL STATUS (CIRCLE ONE) S M D SEP W REFERRED BY _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON RESPONSIBLE FOR BILL (NOT YOUR INSURANCE COMPANY) _____

RESPONSIBLE PERSON'S EMPLOYER & ADDRESS _____

HAS ANY FAMILY MEMBER BEEN TREATED HERE? NO YES NAME _____

EMERGENCY CONTACT NAME _____ PHONE _____

PURPOSE OF VISIT _____

LIST ANY MEDICAL PROBLEMS _____

ALLERGIES TO MEDICATIONS: NO YES (LIST) _____

LIST CURRENT MEDICATIONS _____

NAME OF YOUR PHARMACY _____ PHONE _____

NAME OF PCP/SPECIALIST _____

DO ANY FAMILY MEMBERS HAVE GLAUCOMA? ____ YES ___ NO

LIST ANY OTHER EYE DISEASES IN YOUR FAMILY _____

PAYMENT FOR CO-PAYS AND NON-COVERED INSURANCE SERVICES IS DUE AT THE TIME OF SERVICE.

INSURANCE CLAIMS FOR SURGERY OR ACCIDENTS: Any claims filed on your behalf are to be paid within 45 days from the date of service. You will be billed for any claims your insurance carrier fails to pay within this 45 day period.

I have read the above and understand my financial obligation. I agree to make all necessary payments for services rendered. In addition, I understand that the patient (parent or guardian) is fully responsible for total payment of services including any amounts not covered by any health insurance or prepayment programs the responsible party may have. If the account is turned over for legal collections, the patient (parent or guardian) is also responsible for all cost of collection plus attorney fees.

DATE _____ x_____

SIGNED BY RESPONSIBLE PARTY