DR. JAMES CIMBAK

Optometrist
MAPLE GLEN EYECARE & EYEWEAR
810 Welsh Road
Horsham, PA 19044
215-619-2292
Fax: 215-619-2804

TODAY'S DATE: _____

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____

CIRCLE ONE: Mr. Mrs. Ms. Miss Dr.
MALE__ FEMALE__

ADDRESS: _____

CITY: _____ *STATE:* __ *ZIP:* __

TELEPHONE: Home: _____
Cell: _____

OCCUPATION: _____

PLACE OF EMPLOYMENT: _____
_____

DATE OF BIRTH: _____ *Age* __

WHO REFERRED YOU TO OUR OFFICE? _____
_____

IN CASE OF EMERGENCY CONTACT:

NAME: _____
PHONE #: _____

FAMILY DOCTOR: _____
ADDRESS: _____
PHONE #: _____

INSURANCE INFORMATION

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY #: _____

INSURANCE CO.: _____

GROUP #: _____

EMPLOYER #: _____

PLEASE READ:

I request that payment of authorized insurance benefits be made on my behalf to Dr. James Cimbak for any services furnished me by that physician. 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 payable to related services.

PLEASE SIGN: _____

I understand my insurance contract is between myself and my insurance carrier. I am ultimately the party responsible for payment.

PLEASE SIGN: _____

Do you have an e-mail address?
_____