MAPLE GLEN EYECARE

Dr. James Cimbak & Dr. Jennifer Anderson
701 Limekiln Pike, Suite #4
Maple Glen, PA 19002
(215) 619-2292
Fax: (215) 619-2804
maplegleneyecare@gmail.com

TODAY'S DATE: _____

PATIENT INFORMATION:

LAST NAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____ Age ___

SOCIAL SECURITY #: _____

CIRCLE ONE: MALE FEMALE

OTHER

ADDRESS:

_____

_____

CITY: _____

STATE: _____ ZIP: _____

PHONE #: Home: _____

Cell: _____

EMAIL ADDRESS:

_____

OCCUPATION: _____

PLACE OF EMPLOYMENT:

_____

FAMILY DOCTOR:

_____

ADDRESS: _____

_____

PHONE #: _____

WHO REFERRED YOU TO OUR OFFICE?

_____

IN CASE OF EMERGENCY CONTACT:

NAME: _____

PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE HOLDER:

_____

PATIENT RELATION (circle one):

SELF SPOUSE CHILD

MEDICAL INS. COMPANY/ID:

_____

VISION INS. COMPANY/ID:

_____

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: _____

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

PLEASE SIGN: _____