Harmon Ophthalmology, PC

Instructions: Please fill in the blanks and bring the completed form with you for your first visit to Dr. Harmon's new office.

Patient Information						
First Name, MI	**Last Name**	**Sex**	**Marital**	**DOB**	**Age**	**SSN**

Address	**City**	**State**	**Zip**

Home Phone	**Home Fax#**	Cell Phone	Email Address	**NYH Chart#**	**IDX MRN**

Employer Name	Employer Address	City, State	Zip	Work Phone	Work Fax #

Mother's Name	Mother's DOB (***Peds Pts Only***)	Father's Name	Father's DOB (***Peds Pts Only***)	Patient's Birthplace
Reason for visit				
PERSON TO CONTACT IN CASE OF AN EMERGENCY				
Emergency Contact's Name	Relationship	Home Phone	Work Phone	

Your Physicians				
Referring Physician's Name				
Address	City	State	Zip	Phone
Primary Care Physician Name				
Address	City	State	Zip	Phone

Your Insurance Information					
PRIMARY Insurance Name	**Certificate/Policy #**		**Group #**	**Phone**
Address	**City**		**State**	**Phone**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**
SECONDARY Insurance Name	**Certificate/Policy #**		**Group #**	**Phone**
Address	**City**		**State**	**Phone**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Weill Cornell physicians, having treated me to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and makes copies of all medical records related to such care and treatment. I hereby assign transfer and set over to Weill cornel Physicians sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.
(Medicare insured only)I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician furnishing the services or authorized such physician to submit a claim top Medicare for payment to me.

_______________________________________   ____________________

Signature of Patient or Authorized Guardian   *Date*