

PAMELA A. WEBER, M.D., P.C.
ISLAND RETINA
1500 WILLIAM FLOYD PARKWAY SUITE 304
SHIRLEY, NY 11967
631-924-4300 - FX#: 631-924-2525

PLEASE PRINT CLEARLY

Patient Name _____

Responsible Party/Parent Name _____

Address _____

Street City State Zip

Home Phone# _____

Patients SS# _____ Sex M - F Birth Date _____ Age _____

Family Doctor _____ Address _____

Telephone# _____

Occupation _____ Employer _____ Bus. Phone# _____

Marital Status S M W Spouse's Full Name _____

In Case of Emergency _____ Relationship _____ Phone# _____

Do You Wear Glasses? Yes _____ No _____

Did You Bring Them With You? Yes _____ No _____

Referred to This Office by: ___ Doctor (Name) _____

___ Yellow Pages ___ Internet ___

INSURANCE INFORMATION:

Primary Company _____ Address _____

ID# _____ Group# _____ Phone# _____

Subscriber _____ Relationship to Subscriber _____

DATE OF BIRTH OF SUBSCRIBER _____ SUBSCRIBER SS# _____

Secondary Company _____ Address _____

ID# _____ Group# _____ Phone# _____

Subscriber _____ Relationship to Subscriber _____

DATE OF BIRTH OF SUBSCRIBER _____ SUBSCRIBER SS# _____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payments of services rendered

I request that payment of authorized Medicare or other insurance carrier benefits be made on my behalf to the doctors of Eastern Long Island Retina Associates for any services furnished me by those physicians. I authorize any holder of medical information about me to release to my insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, I understand that annual deductible amounts and all co-insurance amounts are my responsibility. If I have assigned my medical benefits to any other party (H.M.O.), rendering this office ineligible for payment. I understand that I will be responsible for the entire bill for services.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT

Patient X _____ Responsible Party _____ Date _____
(Parent If Minor)