

New Patient Information



Howard H. Rosenblum, MD
Physician and Ophthalmic Surgeon

(please print)

Last Name _____ **First** _____ **Middle** _____ **Date of Birth** _____

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

Occupation _____ **Employer** _____

Phone: Home _____ **Work** _____ **Cell** _____

MALE **FEMALE** **Marital Status:** **M** **S** **W** **D** **SS#** _____

Spouse **or Parent's** **Name** _____ **Work Phone** _____

Emergency Relative or Friend _____ **Relationship** _____ **Phone** _____

Personal Physician _____
Who referred you to this office? _____

❖ **PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST** ❖

Person responsible for payment, if not above:
Name _____ **Relation to patient** _____ **Phone** _____
Address _____

READ CAREFULLY:

- **REGARDING INSURANCE:** **Refraction** (optical or vision exam) is usually **not covered** by medical insurance. I accept full responsibility for payment of my bill including any deductibles, non-covered services or in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary Care Physician prior to being seen in this office. If seen without a referral, I will be responsible for any services rendered.
- **BROKEN APPOINTMENTS:** Please give **24 HOURS NOTICE**, if an appointment needs to be cancelled. Appointments missed without 24 hours notice may necessitate a charge.

AUTHORIZATION: I agree to the above. I request that payment of Medicare or other insurance benefits be made on my behalf to this office for services furnished to me by Dr. Rosenblum. I authorize any holder of medical information about me to release to Medicare, or other insurer and its agents, information needed to determine these benefits.

SIGNATURE _____ **DATE** _____