

**PITTBURGH OCULOPLASTIC ASSOCIATES, Ltd.**

Acct # \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License No: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone No: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Retired? \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Relation to You: \_\_\_\_\_

**GUARANTOR INFORMATION (Person responsible for Payment of Account)**

Guarantor Name: \_\_\_\_\_ Guarantor's Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Guarantor's Employer: \_\_\_\_\_

Guarantor's Social Security #: \_\_\_\_\_

Guarantor's Date of Birth: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary**

Name of Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer: \_\_\_\_\_

**Secondary**

Name of Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer: \_\_\_\_\_

**Other**

Medical Assistance Program Recipient ID# \_\_\_\_\_ Card Issue # \_\_\_\_\_

Worker's Compensation/Auto Accident/Trauma (Circle and Complete on Reverse Side)

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Pittsburgh Oculoplastic Associates. Ltd. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of any information needed to determine these benefits payable for related services. I am financially responsible for the deductible co-insurance, and non-covered services. Co-payments and non-covered services are to be paid at the time services are rendered. I understand that I am to forward any payment that I may receive from my insurance carrier for services rendered. I have read and understand the payment policy of Pittsburgh Oculoplastic Associates.

Signature of Patient/Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

Signed by Policy Holder (If other than patient) \_\_\_\_\_

**ACCIDENT CLAIM INFORMATION**

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Date of Accident: \_\_\_\_\_

Type of Accident (Circle One): Worker's Compensation    Automobile    Other

Claim Number: \_\_\_\_\_

Insured Party: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Claim Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Name of Claim Representative: \_\_\_\_\_

Policy Limit Amount: \_\_\_\_\_