Bausch and Jones Eye Associates

1616 W. Allen Street • Allentown, PA 18102
Tel: 610-432-0201 • Fax: 610-434-1210

WELCOME TO OUR OFFICE

Today's Date _____ Age_____

Patient _____ Date of Birth _____

Name of Person Legally Responsible *(if patient is a Minor, Name of Parent, Guardian, etc.)* _____

Home Address _____
Street *City* *Zip*

Home Phone _____ Cell Phone _____

Email _____ Preferred Pharmacy & Location _____

Patient Employed by _____ Occupation _____
(Or Responsible Person)

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

Name of Spouse _____
First Name *Middle Name* *Maiden Name* *Last Name*

Spouse Employed by _____ Occupation _____

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

How did you find out about our office? _____

Relative or friend not living with you *(for emergency purposes)* _____ Phone (w)_____ (h)_____

Name of Family Physician _____

Do you have Medical or Surgical Insurance? ☐ No ☐ Yes Medicare No. _____

Insurance Company _____

Group and Membership Number _____

COMMUNICATION CONSENT

It is the office policy of Bausch & Jones Eye Associates and staff not to release confidential and/or unauthorized information by home telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the patient. Also, information will not be left with an unauthorized person who may answer the telephone.

This authorizes Baush & Jones Eye Associates and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home / Answering Machine_____ ❑ Yes ❑ No

Work _____ ❑ Yes ❑ No Cell _____ ❑ Yes ❑ No

If you would like to have information released to someone other than yourself, please list the names and relationship of authorized people:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I, the undersigned, verify that the above information is correct. I give permission to Bausch & Jones Eye Associates to file my medical insurance claims for me and to release any medical records necessary to accomplish this filing process. I will be responsible for any non-covered service by my insurance.

Signature: _____ Date: _____