ADVANCED OPHTHALMOLOGY INC.

Specializing In:
Cataract Surgery
Diabetes
Glaucoma
Laser Vision Correction
Comprehensive Eye Care
Contact Lenses

Patient Information:

Name (Last, First, M.I) ______________________________ Birthdate ______________________

Sex (Circle One): M F Marital Status (Circle One): Single Married Divorced Widowed

Street Address ______________________________ City ____________________ State ______ Zip __________

Home # ______________________ Work # ______________________ Cell # ______________________

Email Address ____________________________ SSN _________________ Occupation _______________

*In compliance with the American Recovery and Reinvestment Act of 2009, we are required to capture this data to demonstrate "Meaningful Use". Please fill in the blank.

RACE: ___________________ ETHNICITY: ___________________ LANGUAGE: ___________________

Other Information:

Emergency Contact ____________________ Relationship ________________ Best Phone # __________________

Primary Care Doctor ____________________________ Referring Doctor _________________________________

Pharmacy Name _____________________ Location ___________________ Phone # ____________________

Insurance Authorization and Assignment of Benefits:

Primary Insurance ____________________________ Secondary Insurance_____________________________

Primary Policy Holder's Name ________________________ Birthdate ________________ Sex: M F

Primary's SSN ________________________ Relationship (Circle One): Self Spouse Child Parent Other

I hereby authorize Advanced Ophthalmology Inc. to treat me. I certify the information I have provided above is true and correct. I further authorize the release of any information necessary for the completion of insurance claims. I authorize payment directly to Advanced Ophthalmology Inc. for all routine, medical, and/or surgical services rendered under the terms of my insurance. I understand that I am financially responsible for all copays, coinsurance, deductibles and any charges not paid by my insurance. I permit a photocopy of this authorization to be used as effective and valid in place of the original.

Patient or Guardian Signature ____________________________________ Date __________________

Babur B. Lateef, M.D
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