Allegheny Eye Associates, LLC
John M. Shields, OD

Today's Date: ___________

Patient's Name (as appears on Insurance Card): ________________________________ Preferred Name: __________

Date of Birth: _____/_____/_____ Sex: M F (Please Circle) Soc. Sec. No: ____-____-______

Patient's Occupation: ____ Marital Status: S M (Please Circle)

Street Address/PO Box: ____

City/State/Zip Code: ____

Phone: Cell: ____-____-______ Home: ____-____-______ Email: __________________________________

Name of Spouse/Parent/Guardian: ____

Family/Referring Physician: ____

Whom may we thank for referring you to our care? ____

Insurance Billing Information

Medical Insurance Coverage: ____

Name/Birthday of Insured Person: _____________________________________ _____/_____/_____

Relationship: Self Spouse Dependent Child Other (Please Circle)

Vision Insurance Coverage: ____

Name/Birthday of Insured Person: _____________________________________ _____/_____/_____

Relationship: Self Spouse Dependent Child Other (Please Circle)___________________________

Health/Eye History

Family Doctor: ___________________________

Please list all medications and supplements you are taking:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Are you allergic to any medications? Y N (Please Circle) If yes, please list: ______________________________

Women: Are you pregnant/nursing? Y N

Do you wear any glasses? Y N

Do you wear contact lenses? Y N Brand/Power: Right ____

Brand/Power: Left ____

Do you or any blood relatives have a history of any of the following? (Please indicate who)

Diabetes: _________________ Glaucoma: ____________ Retinal Detachments: _____________

Macular Degeneration _____________ Eye Tumors: _______________

Patient Authorization to Bill Medical/Vision Insurance

By signing below I authorize the office of Allegheny Eye Associates, LLC/John Shields, OD to bill my medical insurance company for any medical care or procedures performed today and to release, when necessary, information acquired during the course of my examination or treatment.
I authorize payment to be made to Allegheny Eye Associates, LLC. I understand that my insurance will be billed: however I will be responsible for any balance remaining after the insurance has made payment. All co-pays, deductible amounts and coinsurance amounts are the responsibility of the patient.

________________________ ________________________

Patient Signature Witness

Date: ______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________