ATLANTIC EYE CENTER **207 Stone Harbor Blvd, CMCH, NJ 08210** **609-465-1616**

(PLEASE PRINT)

Patient Name: ______________________________ **DOB**: ______________

Address: ____

Phone (Primary): ____________ **(Secondary):** ____________ **(Work):** ____________

E-mail Address: ______________________ SS#: ______________

Marital Status: __________ **Preferred Language**: __________ **Male/Female** _____ **Race:** __________

Ethnicity: __________ **Occupation/Student Grade:** ______________________

Primary Physician: ______________________ **Phone#:** ______________

Emergency Contact
Name/Phone#/Relationship: ______________________________________

If patient is a minor Parents/Guardian Information:

Name: ______________________ **Phone:** ____________ **Relationship:** ____________

Medical Update:

Allergies: ____
Reaction: ____

Major Illnesses and Surgeries: (diabetes, high blood pressure, glaucoma, heart, cancer, ect)

____
____
____

Medication List with Dosage:

____
____
____
____
____
____
____

If patient has Medical and/or Financial Power of Attorney or Living Will, this must be sent to the office ASAP.

Power of Attorney
Name______________________ Phone______________ Relationship__________

ATLANTIC EYE CENTER **ATLANTIC EYE CENTER OPTICAL** **CAPE CATARACT CENTER**

207 Stone Harbor Blvd, CMCH, NJ 08210 609-465-1616

I, ____________________________________authorize Atlantic Eye Center to charge my credit/debit card for the balance NOT paid by my insurance (copays, deductibles and coinsurance amounts.) I give permission to only charge an amount per month not to exceed $100.00, unless otherwise authorized by me. I assign my insurance benefits to the provider listed above. I understand that this form can only be used when filled out completely and is valid unless I cancel this authorization in written notice to Atlantic Eye Center. If your credit card has expired, we will give you one written courtesy notice to update. Failure to contact us with an update will result in the $10.00 fee FOR FUTURE BILLS.

*********Please note effective 1/2/2013, if you decline to participate in the ***********

EASY PAY CONSENT PROGRAM

a $10.00 billing fee will be assessed for future bills on your account.

PLEASE PRINT

Patient Name____________________________________

Cardholder Name____________________________________

Cardholder Address____________________________________

City____________________ **State**____________________ **Zip**____________

Credit Card # ______________________________ Visa____ Master Card_____ Discover_____

Expiration Date____________________ **3 Digit Security Code**____________________

Cardholder Signature____________________________________

Date______________ **Email Address**____________________________________

Do you want a receipt? Yes______ No______ If yes, check one: fax _________ Email _________ Mail ___________

____**I DECLINE the EASY PAY CONSENT and I am aware there will be a $10.00 billing fee added to my bill. I agree to pay this $10.00 billing fee.**

Signature____________________________________

Print______________________________ **Date**____________________

10/2022