BRANDYWINE VISION
•ASSOCIATES•

410 W. Linfield Trappe Road • Suite 130, Royersford, PA 19468
Phone: 610.495.7050 • Fax: 610.495.7018

Patient Registration and Health History

Personal Information

Date:_____/_____/_____

Patient Name:_____

Address:_____

_____
City State Zip

Home Phone Number:_____

Work Phone Number:_____

E-mail Address:_____

Sex: ☐ Male ☐ Female

Birthdate:_____/_____/_____ Age:_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation:_____

Employer:_____

Whom may we thank for referring you?_____

_____

What is your reason for seeking vision care at

this time?:_____

_____

Insurance Information

Identification Number:_____

Primary Insured:_____

Relationship to Patient:_____

Insurance Company:_____

Primary's Employer:_____

Primary's DOB:_____/_____/_____ SS#_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. DeAngelis & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party's Signature

_____ _____/_____/_____
Relationship Date

Medications

List all medications you are currently taking, including eye drops. Please include any vitamins and/or nutritional supplements:

_____
_____
_____
_____

Allergies

List your allergies to medications or other substances:

_____
_____
_____
_____