

**HARTZELL RUPP OPHTHALMOLOGY, P.C.**  
**3 Baden Powell Lane, Suite 4, Mechanicsburg, PA 17050**

PATIENT INFORMATION				
Last Name:		First:		Middle:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth:     /     /		Age:		Social Security #:
Address:		City:		State:
Home Phone:		Cell Phone:		Zip:
Occupation:		Employer:		Employer Phone:
Chose office because/Referred by: <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Advertisement <input type="checkbox"/> Other _____				
INSURANCE INFORMATION				
Person responsible for bill:			Date of Birth:     /     /	
Address (if different):			Home phone:	
Occupation:			Employer:	
Employer address:			Employer Phone:	
<b>Primary Insurance:</b>		Policy #:		Group #:
Subscriber:		Subscriber's SS#:		Date of Birth:     /     /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				Co-Payment: \$
<b>Secondary Insurance:</b>		Policy #:		Group #:
Subscriber:		Subscriber's SS#:		Date of Birth:     /     /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):				
Relationship to Patient:		Home phone:		Work phone:
<p>The above information is true to the best of my knowledge. I request payment of authorized insurance benefits to be made either to me or on my behalf to Hartzell Rupp Ophthalmology, P.C. for any services furnished to me by Hartzell Rupp Ophthalmology, P.C. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for any balance.</p>				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	