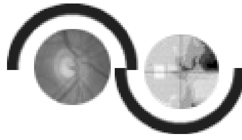

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Associate Professor of Ophthalmology
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Johns Hopkins University

Adam C. LePosa, OD
Residency Trained in Ocular Diseases
Specializing in Glaucoma and
Comprehensive Eye Care

PATIENT INFORMATION

NAME: ______________________________

ADDRESS: ______________________________

CITY, STATE AND ZIP: ______________________________

HOME PHONE: ______________________ WORK PHONE: __________

EMAIL ADDRESS: ______________________ CELL PHONE: __________

SEX: __________ RACE: ______________ MARITAL STATUS: M D W S SEP.

DATE OF BIRTH: ______________________ PRESENT AGE: __________

SOCIAL SECURITY #: ______________________________

EMPLOYER: ______________________________

REFERRED BY: ______________________ PHONE #: __________

MEDICAL MD: ______________________ PHONE # __________

ADDRESS: ______________________________

CITY, STATE, AND ZIP: ______________________________

PHARMACY NAME: ______________________________

PHARMACY PHONE NUMBER: ______________________________

SPOUSE NAME AND PHONE #: ______________________________

SPOUSE EMPLOYER: ______________________________

PERSON NOT IN HOUSEHOLD TO CONTACT: ______________________________

PHONE #: ______________________ RELATIONSHIP: __________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________________

ADDRESS: ______________________________

____

POLICY #: ______________________ GROUP #: __________

SUBSCRIBER NAME: ______________________________

SUBSCRIBER ADDRESS: ______________________________

SUBSCRIBER DATE OF BIRTH: ______________________________

SUBSCRIBER SOCIAL SECURITY #: ______________________________

RELATIONSHIP: ______________________________

(***OVER PLEASE)***

INSURANCE INFORMATION CONTINUED

SECONDARY INSURANCE: ______________________________

ADDRESS: ______________________________

____

POLICY #: ______________________ GROUP #: __________

SUBSCRIBER NAME: ______________________________

SUBSCRIBER ADDRESS: ______________________________

SUBSCRIBER DATE OF BIRTH: ______________________________

SUBSCRIBER SOCIAL SECURITY #: ______________________________

RELATIONSHIP: ______________________________

TERTIARY INSURANCE: ______________________________

ADDRESS: ______________________________

____

POLICY #: ______________________ GROUP #: __________

SUBSCRIBER NAME: ______________________________

SUBSCRIBER ADDRESS: ______________________________

SUBSCRIBER DATE OF BIRTH: ______________________________

SUBSCRIBER SOCIAL SECURITY #: ______________________________

RELATIONSHIP: ______________________________

LIFETIME ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE TO ME OR ON MY BEHALF TO ALAN L. ROBIN, MD, PA FOR ANY SERVICES FURNISHED ME BY THAT FACILITY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES.

I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE BECAUSE OF CO-PAY, DEDUCTIBLE, REFERRAL/AUTHORIZATION NOT OBTAINED PRIOR TO VISIT, OR INCORRECT INSURANCE INFORMATION."

SIGNATURE: ______________________ DATE: __________

PRINT NAME: ______________________________

(OTHER AUTHORIZED OR REQUIRED TO CONSENT)

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