



Our Focus is on you...

Board Certified Renowned Specialists.

The Care & Quality You Deserve.

Chelsea Eye & Cosmetic Surgery Associates Patient Information

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: (mm/dd/yyyy) _____

Marital Status: _____ Gender _____ Email Address: _____

Single Married Divorced Widowed Domestic Partner

Who Shall We Thank for Referring You or how did you hear about us?

Primary Care Physician: _____ Phone # _____

Patient's Employer: _____ Work Phone # _____

Address: _____ Occupation: _____

City: _____ State: _____

Emergency Contact:

Person to Contact: _____

Relationship: _____ Phone # _____

INSURANCE (for non-cosmetic patients) :

Primary _____ Secondary _____

Policy # _____ Policy # _____

Subscriber: _____ Date of Birth: _____ Soc. Sec. # _____

Chelsea Eye's physicians are specialists in the elective procedures listed below.

Please **Check** any in which you have an interest.

Lasik Botox Collagen (Fillers) Eyelid Plastic Surgery Facial Plastic Surgery

Skin Treatments Laser Hair Removal Liposuction

I realize that all office visits are to be paid at the time services are rendered unless previous arrangements have been made. I authorize the release of any medical information necessary to process my insurance claims. I consent to the photography if medically indicated and authorize release of payment for medical benefits to be made directly to the physicians of Chelsea Eye Associates, LLP.

Patient Signature

Date

" NOTICE OF PRIVACY PRACTICES" REVIEWED BY PATIENT