Persila V. Mertz, MD, PC

115 E. Main St

Ephrata, PA 17522

Patient Information Form

1. Patient Information

Name: _____ Date of Birth_____

Address: _____

Email: _____ Phone: _____

Marital Status: S M D W Sex: Male Female SSN: _____

Spouse's name (or next of kin) _____

Power of Attorney: _____Power of Attorney Phone: _____

Emergency Contact and Phone Number: _____

Relationship to patient: _____

Primary Care Physician: _____ Optometrist: _____

How did you hear about our practice? _____

2. Guarantor Information (if different from patient)

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

SSN (**MUST** have): _____

3. Insurance Information

Primary Ins.: _____ Policy No. _____ Group No. _____

Address: _____

Secondary Ins: _____ Policy No. _____ Group No. _____

Address: _____

4. Employer Information

Name of Employer: _____ Occupation: _____

Employer's address: _____

I request that payment of authorized insurance benefits be made on my behalf to Persila V Mertz, MD, P.C. I authorize release of any medical information about me to my insurance companies in order to process claims and determine benefits and benefits payable. I understand that copayments, deductibles and all non-covered charges are my responsibility.

_____ _____

Signature Date