the eye clinic p.c.

PATIENT INFORMATION

First:_____ MI: ___ Last: _____ Nickname: _____ Date of Birth: ___/___/___ ☐Male ☐Female

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Cell Carrier: _____

May we leave a confidential message at the above phone numbers? ☐Yes ☐No Email: _____

Please contact me with appointment reminders at: ☐E-Mail ☐US Mail ☐Phone-Cell ☐Phone-Home ☐Phone-Work

Employer: _____ Occupation: _____ Social Security #: _____

Emergency Contact Name: _____ Phone: _____ Other Phone: _____

Preferred Language:	Race:		Ethnicity:
☐English	☐American Indian or Alaska Native	☐White	☐Not Hispanic or Latino
☐Spanish	☐Asian	☐Other	☐Hispanic or Latino
☐Other _____ (Please indicate)	☐Black or African American	☐Decline to Answer	☐Unknown
	☐Native Hawaiian or Other Pacific Islander		☐Decline to Answer

PHYSICIAN INFORMATION

Your Primary Care Doctor Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Co: _____ Subscriber Name: _____ ☐Male ☐Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance Co: _____ Subscriber Name: _____ ☐Male ☐Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Vision Insurance Co: _____ Subscriber Name: _____ Male Female

ID#: _____ Group #: _____ Subscriber Date of Birth: ____/____/____

Subscriber SSN: _____-___-_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

AUTHORIZATION TO RELEASE INFORMATION / PAY BENEFITS DIRECTLY TO PHYSICIAN

I hereby authorize the release of any information requested by my insurance carrier concerning my present illness or injury.
I also assign to the group/physician whose name appears above all money to which I am entitled for medical and/or surgical expenses relative to the services reported. I permit a copy of this authorization to remain on file and be used in place of an original signature for claims filed.
I understand that I am financially responsible to said group/physician for charges not covered by this assignment.
I also understand that I will continue to be billed on all accounts not paid. If an insurance claim is pending, The Eye Clinic, PC will not be responsible for collecting and/or negotiating settlement on a disputed claim.

Patient/Responsible Signature: _____ Relationship: _____ Date: _____