

Patient Information Form



Patient Name: Mr Mrs Ms _____ **Date of Birth:** _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ ext: _____

Gender: M F **Are you Hispanic or Latino?** Y N **Primary Language:** _____

SSN# _____ **Preferred method of contact:** Home Cell Work E-mail Mail

Race: American Indian or Alaska Native Asian Black or African American Pacific Islander White

Patient Employer: _____

Patient E-mail Address: _____

Person to contact in case of Emergency: _____

Relationship: _____ **Phone:** _____

Responsible Party/Guarantor Information

Name: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ ext: _____

Employer: _____ **SSN:** _____ **Date of Birth:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail Address: _____

Insurance Information

Medical Insurance

Insured Party: _____ **Relationship to Patient:** _____

Insured Date of Birth: _____ **Insured SSN#** _____

Insured Employer: _____

Insurance Company: _____

Insurance ID# _____ **Insurance Group#** _____

Do you have supplemental insurance? Y N **If yes, name of company** _____

Vision Insurance

Insured Party: _____ **Relationship to Patient:** _____

Insured Date of Birth: _____ **Insured SSN#** _____

Insured Employer: _____

Insurance Company: _____

Insurance ID# _____ **Insurance Group#** _____

Patient Information Form



Health Information

Primary Care Doctor _____

Smoking Status: Never Former Smoker Smoke Every Day Smoke Socially

Height: _____ Weight: _____

Allergies: _____

Preferred Pharmacy: _____

Current List of Medications (please use additional pages if needed):

If you already have a pre-made list please bring it with you to the appointment

Medication	Strength	Frequency	# Per Bottle <small>(30 for a 30 day supply)</small>	Condition

Authorization and Release

I authorize my insurance company to pay EyeCare Specialties, insurance benefits that would otherwise be payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that I am responsible for all co-pay's, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.

By signing this authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me, unless I say otherwise. Thus, I understand and agree that any phone numbers and e-mail addresses provided by myself to EyeCare Specialties and to any of our service providers may leave messages for me manually and by using automated systems such as artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers place to me, I consent and agree that those calls may be automatically dialed and that EyeCare Specialties and our service providers may use recorded messages. I also agree that EyeCare Specialties and any service providers may contact me by sending text messages and e-mails to any phone number or e-mail address I provide to this office or service providers, and I consent to receive such text messages and e-mails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____

HIPAA Privacy Policy Acknowledgment of Receipt

I acknowledge that I was given the opportunity to receive a copy of EyeCare Specialties Notice of Privacy Practices.

Patient Name: _____ Signature: _____ Date: _____

Release of Records

I authorize EyeCare Specialties to disclose my protected health information (PHI) to:

Spouse: _____ Other: _____

Authorization Expiration Date (a date is required if authorization is given): _____