

THE CENTER FOR EYE CARE

Date: _____

Name: _____ Gender: _____

Soc Sec Number: _____ Birth Date: _____ Age: _____

Address: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Home Ph: _____ Cell/Other Ph: _____

Employment: _____ Work Ph: _____

Best Time and Place to Reach You: _____ Email address: _____

Referred: Radio Yellow Pages TV Newspaper Friend Screening Other _____

Information for Insured Party:

Name: _____ **Birth Date:** _____

Soc Sec Number: _____ **Employer:** _____

Information for Spouse / Parent / Guarantor: (Circle One)

Name: _____ Birth Date: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Employer: _____

Home Ph: _____ Work Ph: _____ Cell/Other Ph: _____

In Case of Emergency, contact (Specify someone who does not live in your house)

Name: _____ Relationship: _____

Home Ph: _____ Cell/Other Ph: _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance with _____ and assign directly The Center for Eye Care all insurance benefits (including Medicare, Medicaid, and/or Medigap benefits, if applicable) otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. To the extent permitted by law, The Center for Eye Care may use my health care information and may disclose such information to the above named Insurance Company(ies) (including Medicare, Medicaid, and/or Medigap benefits, if applicable) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

THE CENTER FOR EYE CARE

I, _____ hereby authorize the physicians and the staff of **The Center for Eye Care**, to give the following people information concerning my health and well being.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The following information may be given to the above individuals:

_____ Appointment Time

_____ Medications

_____ Procedures

_____ Test/Lab results

_____ Billing/Finance Information

_____ Any other information regarding my health

I also authorize **The Center for Eye Care** to leave a message on my answering machine or voicemail Regarding upcoming appointments

_____ Yes

_____ No

I understand that I may revoke this consent at any time by giving written notice to **The Center for Eye Care**. I have been informed of the Notice of Privacy Practices for **The Center for Eye Care** and acknowledge that it is my right to keep a copy of it for my records.

Signature of Patient / Parent / Legal Guardian

Date