THE EYE CENTER

MEDICAL & SURGICAL EYE CARE

Patient Information

Name _____
Last Name First Name Middle Initial

Soc. Sec. # _____ Date of Birth _____ Sex ☐ M ☐ F

☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐Separated

Address _____ Home Phone _____

City _____ State _____ Zip _____

Out of Town Address (if any): _____

Employer (if any) _____ Business Phone _____

Business Address _____ Occupation _____

Emergency Contact _____
Name Relationship Phone

Responsible Party

☐ Check if Patient is the Responsible Party

Responsible Party Name: _____
Last Name First Name Middle Initial

Address: _____
Address City State Zip

Employer: _____
Address City State Zip

Responsible Party Home Phone _____ Work Phone_____ DOB _____

Who Referred You to Our Office?

_____ Your Optometrist Name _____

Date of last eye examination: _____

_____ Your Doctor Name: _____

_____ Another Patient Name: _____

_____ Newspaper _____ Newsletter _____ Television _____ Radio

_____ Yellow Pages _____ Vision Screening _____ Home Visit

_____ Other Please explain _____

Last Name: _____ First _____ DOB _____

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize the release of my medical information to my insurance company and the assignment of benefits from my insurance company to The Eye Center.

Patient/Parent/Guardian Signature _____

Date _____

PATIENT RESPONSIBILITY FOR PAYMENTS: In being accepted as a patient of The Eye Center, I realize that I am responsible for all charges incurred. Payment for services is due the day services are provided (unless prior arrangements are made in writing.) I understand that The Eye Center will file my insurance for me, but I am responsible for deductibles, co-payments, uncovered services, and claims denied by my insurance company.

Patient/Parent/Guardian Signature _____

Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that The Eye Center has the right to change this notice at any time. I may obtain a current copy by contacting The Eye Center.

Patient/Parent/Guardian Signature _____

Date _____