Professional Eye Associates
Patient Information

Date: _____

Name: _____ Birth date: _____ SS#: _____-_____-_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

E-mail Address: _____ ☐ No email address

Preferred method of communication: ☐ Home ☐ Cell phone ☐ Work ☐ Email ☐ Text message

Mailing Address: _____ City/State/Zip: _____

Street Address: _____ City/State/Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race: ☐ White ☐ Black ☐ Asian ☐ Other: _____

Primary Physician: _____ Practice Name: _____

MEDICARE PATIENTS: Mother's maiden name: _____ Patient's Birth State: _____

Alternate Contacts: Please list persons we may contact to discuss your medical information or in the event of an emergency.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

MINORS / DEPENDENT CHILDREN: If patient is a minor or under guardianship care, please complete the following:

Name of Mother/Guardian: _____ Birth date: _____ SS#: _____-_____-_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____ City/State/Zip: _____

Employer: _____

Name of Father/Guardian: _____ Birth date: _____ SS#: _____-_____-_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____ City/State/Zip: _____

Employer: _____

Please be advised: We must have a copy of your valid photo ID and current insurance card(s) on file.

Please complete the other side of this form.

INSURANCE INFORMATION

1) Medical Insurance: _____ Policy #: _____

Name of Policy Holder: _____ Birth date: _____ SS#: _____-_____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

2) Medical Insurance: _____ Policy #: _____

Name of Policy Holder: _____ Birth date: _____ SS#: _____-_____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

3) Vision Plan: _____ Policy #: _____

Name of Policy Holder: _____ Birth date: _____ SS#: _____-_____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

ASSIGNMENT OF BENEFITS AND/OR AUTHORIZATION FOR TREATMENT

I hereby authorize treatment of the person listed above and further authorize that any payment of benefits be made to the provider of these services on the patient's behalf. I will notify Professional Eye Associates in writing should I wish to revoke this authorization.

Patient or Guardian's Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient:_____

DISCLOSURE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Patient or Guardian's Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient:_____