## 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 com	munication:  Home	☐ Cell phone ☐ Work ☐ Em	ail Text message		
Mailing Address:		City/St	ate/Zip:		
Street Address:		City/St	ate/Zip:		
	☐ Married ☐ Widowed	h Spanish Other: o Non-Hispanic or Latino sian Other:			
Primary Physician:		Practice Name:	Practice Name:		
MEDICARE PATIENTS	S: Mother's maiden n	ame:	Patient's Birth State:		
Alternate Contacts: Ple emergency.	ease list persons we m	ay contact to discuss your medi	ical information or in the event of an		
Name:		Phone #:	Relationship:		
Name:		Phone #:	Relationship:		
Name:		Phone #:	Relationship:		
MINORS / DEPENDEN	T CHILDREN: If pa	tient is a minor or under guardian	ship care, please complete the following:		
Name of Mother/Guardia	nn:	Birth date:	SS#:		
Home Phone #:	Cell Phone #:	Work	Phone #:		
Address:		City/State/Zip:	City/State/Zip:		
Employer:					
Name of Father/Guardian	n:	Birth date:	SS <u>#:</u>		
Home Phone #:	Cell Phone #:	Work Phone #:			
Address:		City/State/Zip:			
F1					

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:						
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 AU	THORIZATION FOR T	TREATMENT				
I hereby authorize treatment of the person listed above and fit made to the provider of these services on the patient's behalf writing should I wish to revoke this authorization.		• • •				
Patient or Guardian's Signature:		Date:				
Printed Name:	inted Name: Relationship to Patient:					
DISCLOSURE OF PRIVA	ACY PRACTICES					
I understand that as part of my healthcare, this organization origin history, symptoms, examination and test results, diagnoses, treatm understand that this information serves as:  • a basis for planning my care and treatment • a means of communication among the many hea • a source of information for applying my diagnos • a means by which a third-party payer can verify • and a tool for routine healthcare operations such healthcare professionals	ent, and any plans for full lth professionals who co sis and surgical informat that services billed were	ontribute to my care ion to my bill e actually provided				
I understand and have been provided with a <i>Notice of Information</i> information uses and disclosures. I understand that I have the right understand that the organization reserves the right to change their mail a copy of any revised notice to the address I've provided. I unhealth information for directory purposes. I understand that I have information may be used or disclosed to carry out treatment, paym not required to agree to the restrictions requested. I understand that extent that the organization has already take action in reliance their	t to review the notice princtice and practices and inderstand that I have the the right to request restreent, or healthcare operate I may revoke this constitution.	for to signing this consent. I prior to implementation will right to object to the use of my rictions as to how my health tions and that the organization is				
Patient or Guardian's Signature:		Date:				
Printed Name:	Relationship t	o Patient:				