Quality Eye Associates/Center

PATIENT INFORMATION (Please print your information clearly and legibly)

Patient's Name (full legal name, no nicknames): ________________________________ Date of Birth:___-____-____
SS #:______-____-______ Sex (circle): Male Female Marital Status (circle): Single Married Widowed Divorced

Address____City___________________State_____Zip________
Home Phone # ______________________________ Cell Phone/or Work Phone# _______________________________
Occupation ________________________________ Spouse Date of Birth: ___/____/_____
EMAIL ADDRESS:____

Family Physician_______________________________________ Physician Phone #__________________________
Physician Address____

In the event that it is necessary to discuss your personal health information with someone other than yourself, please list the names and phone numbers of the person(s) we should contact:
Person to Contact ___________________________Relationship _______________ Phone # ___________________
Person to Contact ___________________________Relationship _______________ Phone # ___________________

INSURANCE INFORMATION (Please present **ALL** insurance cards each time)
Primary Insurance ____ (Need copy of insurance card)
Subscriber __________________________________ Relationship________________ Date of Birth____/___/______

Secondary Insurance ____ (Need copy of insurance card)
Subscriber __________________________________ Relationship________________ Date of Birth____/___/______

Medication Allergies____

How did you hear about us?
___Referred by Family or Friend (please specify)_________________________________
___Referred by Physician/or Other Eye Doctor (please specify)____
___Previous Patient ___Other______________________________________

Authorizations

I hereby authorize Quality Eye Associates/Center to bill my Insurance, which may include release of Medical Information to process the claim. I also authorize payment to be made directly to Quality Eye Associates/Center.

I acknowledge that I have received and/or read Quality Eye Associates/Center Notice of Privacy Practices.

I acknowledge that this authorization will continually remain in effect from the date of my below signature.

I will be responsible for payment if my insurance company does not pay for the doctor's service.

Patient or Guardian's Signature: ____ Date ____________________