

# Patient Information

DEMOGRAPHICS

NAME <small>LAST FIRST MI</small>			TODAY'S DATE		
STREET ADDRESS			SOCIAL SECURITY #		
CITY			SPECIAL NEEDS: <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> TRANSLATOR <input type="checkbox"/> WHEELCHAIR		
STATE	ZIP CODE	BIRTH DATE	AGE	SEX <input type="checkbox"/> F <input type="checkbox"/> M	
HOME PHONE (      )		WORK/ MOBILE PHONE (      )		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED	
EMPLOYER NAME/ADDRESS			POSITION/DEPARTMENT		
SPOUSE			WORK PHONE/ MOBILE PHONE (      )		
EMERGENCY CONTACT			PHONE		E-MAIL ADDRESS

REFERRAL

PLEASE FILL OUT THIS AREA TO LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE					
NAME OF OPTOMETRIST		PHONE (      )	<input type="checkbox"/> PATIENT: NAME _____ <input type="checkbox"/> OTHER PHYSICIAN _____ <input type="checkbox"/> OTHER (INSURANCE DIRECTORY) _____		
LOCATION					
STREET ADDRESS		CITY	STATE	ZIP CODE	
PRIMARY CARE MEDICAL DOCTOR			PHONE (      )		
STREET ADDRESS		CITY	STATE	ZIP CODE	

BILLING

Guarantor (Person Financially Responsible)					
NAME			RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
STREET ADDRESS			PHONE (      )		
CITY			STATE	ZIP CODE	
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S DOB	
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S B/D	
<input type="checkbox"/> WORKERS COMPENSATION					(over)

### **Agreement of Responsibility**

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: \_\_\_\_\_

### **Consent to Treat**

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: \_\_\_\_\_

### **Acknowledgement of Receipt of Privacy Practices**

I acknowledge that I have received a copy of Omni Eye Specialist's P.A. Notice of Privacy Practices.

Initial: \_\_\_\_\_

### **Release of Information/Assignment of Benefits**

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_