TENNESSEE EYE CARE

PATIENT INFORMATION SHEET

PATIENT: _____ DATE OF BIRTH: _____

ADDRESS: _____ SEX: M ☐ F ☐ AGE: _____

CITY: _____ STATE: _____ ZIP: _____ SSN# _____-_____-_____

PHONE: _____ (HOME) EMAIL: _____

_____ (CELL)

_____ (WORK)

RACE (CHECK ONE):

AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN ☐ CAUCASIAN ☐ OTHER: _____

ETHNICITY (CHECK ONE): HISPANIC ORIGIN ☐ NOT HISPANIC ORIGIN ☐

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

SPOUSE NAME: _____ SPOUSE DOB: _____

SPOUSE SSN: _____-____-_____ SPOUSE PHONE: _____

SPOUSE EMPLOYER NAME: _____

SPOUSE EMPLOYER ADDRESS: _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR): _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

RESPONSIBLE PARTY DOB: _____ RESPONSIBLE PARTY SSN: _____-____-_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

PHONE: _____

PATIENT: _____ DOB: _____

PRIMARY MEDICAL INSURANCE: _____

SECONDARY MEDICAL INSURANCE: _____

VISION INSURANCE: _____

OUR OFFICE FILES INSURANCE AS A SERVICE TO OUR PATIENTS BUT WE CANNOT GUARANTEE PAYMENTS OF BENEFITS.

BY USING OUR SERVICES YOU AGREE TO THE FOLLOWING:

I certify that I (or my dependent) have insurance coverage and assign insurance directly to the provider.

I understand that I am financially responsible for all charges whether paid by my insurance or not.

I authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I agree to pay all charges for myself or my dependent that insurance does not pay.

SIGNATURE: _____ DATE: _____

I acknowledge that I have received or have been offered a copy of HIPAA Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____

PHONE: _____

PHARMACY NAME: _____

ADDRESS: _____

PHONE: _____