Patient Information

Please Print Date_____

Name_____ Gender (Circle one) Male Female

Home Address_____City_____

State_____ Zip _____ E-Mail address_____

Home Phone_____Work Phone_____Cell Phone_____

Social Security Number_____Birth Date_____Age_____

Employer_____

Address_____City, _____State_____Zip_____

Preferred Language_____

Race: (Circle one) American Indian Alaskan Native Asian African American Pacific Islander White Decline to specify

Ethnicity: (Circle one) Not Hispanic or Latino Hispanic or Latino Decline to specify

Person Responsible for your Account:

Name_____Birth Date_____

Address_____Home Phone_____

Social Security Number_____Work Phone_____

Relationship to patient_____

Employer_____Address_____

In case of emergency notify—Name_____Phone_____

Work Phone_____Relationship_____

Referred by_____

I Authorize release of medical information to (name)_____

Relationship to patient: Friend Family Other:_____

THIS SECTION MUST BE COMPLETED TO FILE YOUR INSURANCE MEDICAL INSURANCE INFORMATION

Please bring your Insurance cards to your exam

PRIMARY INSURANCE COVERAGE

Name of Insurance Company_____Phone_____

Address of Insurance Company_____

Policy Holder's Name_____Date of Birth_____

Insurance I.D. Numbers_____Group #_____

SECONDARY INSURANCE COVERAGE

Name of Insurance Company_____Phone_____

Address of Insurance Company_____

Policy Holder's Name_____Date of Birth_____

Insurance I.D. Numbers_____Group #_____

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf for any services furnished me by The Center For Sight, LLC, including physician services. I authorize any holder of medical information about me to release to other physicians and or eye care professionals, also to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize the viewing of medication and pharmacy history that may be provided by other companies and providers.

Signature_____Date_____

***Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill.

Updated by patient or guardian _____Date_____