

PATIENT INFORMATION

Please print-all information confidential!

Miss Mrs. Ms. Mr.

Patient Name

FIRST MI LAST

Social Security # _____ - _____ - _____

Birthdate _____ - _____ - _____ **Age** _____

Address _____

City _____ **State** _____

Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Occupation _____

Medical Doctor: _____

Do you wear glasses?

YES _____ **NO** _____

Do you wear contacts? If Yes

SOFT _____ **HARD** _____

Please list all allergies:

Please list any allergies to medications:

Please list any medications or herbal supplements you are taking:

List any eye surgery and the date: _____

REASON FOR VISIT: (please specify which eye)

INSURANCE INFORMATION

Name of insured _____

Relationship _____

Social Security Number _____ - _____ - _____

Birthdate: _____ - _____ - _____

Insurance Company: _____

Co-pay amount? _____

Name of Secondary Insurance, if applicable:

Name of insured _____

Relationship to patient _____

Social Security Number _____ - _____ - _____

Birthdate: _____ - _____ - _____

By my signature below, I acknowledge that I have received Island Eye Surgery Specialists Notice of Privacy Practices.

X _____
SIGNATURE

DATE

I AUTHORIZE RELEASE OF MEDICAL INFORMATION CONCERNING MYSELF OR MY DEPENDENTS FOR THE PURPOSE OF PROCESSING CLAIMS FOR INSURANCE BENEFITS. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FROM MY INSURANCE COMPANY FOR MEDICAL SERVICES RENDERED. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCES NOT COVERED BY MY INSURANCE BENEFITS.

X _____

DATE _____