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PATIENT INFORMATION FORM

DATE_____ ☐ **NEW PATIENT**

NAME_____ E-MAIL_____

SSN _____ OCCUPATION_____

DATE OF BIRTH _____ EMPLOYER _____

ADDRESS _____ MARITAL STATUS:_____ SEX: _____

_____ **EMERGENCY CONTACT**

HOME PHONE _____ NAME _____

CELL PHONE_____ PHONE_____

WORK PHONE_____ RELATIONSHIP_____

RACE:
__ASIAN
__BLACK
__CAUCASIAN
__ NATIVE AMERICAN
__2 OR MORE
__OTHER

ETHNICITY:
__HISPANIC
__NOT HISPANIC

REFERRING DOCTOR/PERSON [__] _____

PRIMARY CARE PHYSICIAN _____

INSURANCE INFORMATION

COPAY _____

PRIMARY _____

SECONDARY _____

POLICY HOLDER (if not patient)_____ SSN _____

RELATIONSHIP_____ DATE OF BIRTH_____

ADDRESS _____CITY/STATE/ZIP _____

HOME PHONE_____ CELL PHONE_____ WORK PHONE _____

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

_____

Patient 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 AND/OR MEDICARE FOR MEDICAL SERVICES RENDERED. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCES NOT COVERED BY MY INSURANCE BENEFITS.

_____

Patient Signature **Date**