

**PATIENT INFORMATION SHEET**  
**PLEASE COMPLETE AND BRING WITH YOU**

DATE \_\_\_\_\_

**RACE:**

**MARITAL STATUS:**

B \_\_\_\_\_

SINGLE \_\_\_\_\_

H \_\_\_\_\_

MARRIED \_\_\_\_\_

O \_\_\_\_\_

WIDOWED \_\_\_\_\_

W \_\_\_\_\_

DIVORCED \_\_\_\_\_

WHO IS YOUR OPTOMETRIST? \_\_\_\_\_ FAMILY PHYSICIAN? \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ REFERRED BY \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ SPOUSE'S WK PHONE \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_ S.S. # \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER/ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**BILLING ADDRESS** \_\_\_\_\_

ARE YOU COVERED BY A MEDICAL INSURANCE PLAN WITH YOUR SPOUSE'S EMPLOYER?  YES  NO

ARE YOU COVERED BY A MEDICAL INSURANCE PLAN WITH YOUR CURRENT EMPLOYER?  YES  NO

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment benefits apply.

I authorize the release of medical information necessary to process all insurance claims and the payment of benefits to the Thomasville Eye Center.



Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_