

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 _____