The Center For Sight

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PATIENT INFORMATION

New Patient? ☐ How did you hear about our office?
Newspaper ☐ Telephone Book ☐ Physician ☐ Other ____________

Name: ____________ Sex: ______ Date of Birth: ____________ Age: ______

Street: ____________ Social Security #: ____________

City: ____________ State: ____________ Zip: ____________

Telephone: ____________ Marital Status: ____________

Spouse or Parent: ____________ Date of Birth: ____________

Primary Family Physician ____________ Smoker ______ Non-Smoker ______

EMPLOYER

Name: ____________ Occupation: ____________

Street: ____________ City: ____________

State: ____________ Zip: ____________ Telephone: ____________

EMERGENCY CONTACT PERSON OUTSIDE OF HOME

Name: ____________ Relationship: ____________

Telephone (Home): ____________ Work: ____________

INSURANCE INFORMATION

Insurance: ____________ Subscriber: ____________

Group: ____________ Contract: ____________ Date of Birth: ____________

Secondary Insurance: ____________ Subscriber: ____________

Group: ____________ Contract: ____________ Date of Birth: ____________

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of original. I hereby authorize The Center For Sight to apply for benefits on my behalf for rendered services rendered by them or by their order. I request that payment from my insurance company be made directly to The Center for Sight. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I authorize The Center for Sight to disclose my medical record and health information (following HIPAA regulation) to the parties listed below.

1) ____________ 2) ____________ 3) ____________

This authorization will begin: ______/______/______ and will expire: ______/______/______
mo day yr mo day yr

I have been provided a copy of The Center For Sight Notice of Privacy Practice.

Signature ____________ Date ____________

Responsible Party ____________ Date ____________