The Center For Sight

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 _____