

PATIENT INFORMATION

OFFICE USE: _____

DATE _____ REFERRED BY _____

FIRST NAME _____ LAST NAME _____ M.I. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ SEX (M/F) _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ SOCIAL SEC. # _____

FAMILY PHYSICIAN _____ OPTOMETRIST _____

CHECK ONE: MARRIED SINGLE OTHER

CHECK ONE: EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT OTHER _____

EMPLOYER _____ PHONE _____

NAME OF SPOUSE _____ SPOUSE DATE OF BIRTH _____

IN CASE OF EMERGENCY,
ALTERNATE PERSON NOT LIVING WITH YOU _____ PHONE _____

INSURANCE/EMPLOYER INFORMATION

ARE YOU ON MEDICARE? YES NO I.D. # _____

ARE YOU ON MEDICAID/WELFARE? YES NO RECIPIENT # _____

DO YOU HAVE HEALTH INSURANCE? YES NO

IN WHOSE NAME _____

IS YOUR HEALTH INSURANCE THROUGH YOUR CURRENT/PAST EMPLOYER? YES NO

NAME OF THAT EMPLOYER _____

ADDRESS _____

NAME OF INSURANCE COMPANIES

PRIMARY _____ I.D. # _____

ADDRESS _____ GROUP # _____

SECONDARY _____ I.D. # _____

ADDRESS _____ GROUP # _____

I authorize the release of any medical information necessary to process insurance claims on my behalf. I also request payment of medical benefits directly to Tuscarawas Eye Centre, Inc. and agree to be responsible for any charges incurred and not covered by my insurance carrier.

Signed _____ Date _____

RESPONSIBLE PERSON / P.O.A. INFORMATION

*TO BE FILLED OUT IF PATIENT IS A MINOR, UNDER GUARDIANSHIP,
HAS A CUSTODIAN, OR IS NOT FINANCIALLY RESPONSIBLE.*

RESPONSIBLE PARTY

First Name _____ Last Name _____ M.I. _____

Address _____

City _____ State _____ Zip _____ Sex (M/F) _____

Home Phone _____ Work Phone _____

Date of Birth _____ Social Sec. # _____

Check One: Employed Full-time Student Part-time Student Other

Marital Status: Married Single Other

Employer _____

RELEASE TO TREAT A MINOR

As responsible person for _____, I hereby grant authorization to Tuscarawas Eye Centre, Inc. for medical treatment as may be deemed necessary for his/her eye care.

Signed _____ Date _____

Relationship _____