PATIENT INFORMATION SHEET

CHART#:__________

DATE____________ REFERRED BY________________________

PATIENT'S FULL NAME________________________________HOME PHONE: (____)____________

ADDRESS____
street city state zip

EMAIL ADDRESS: __________________________________ CELL / PAGER# ____________________

SEX_______BIRTHDATE_______________AGE_______SOCIAL SECURITY#____________________
MM/DD/YYYY

PATIENT'S EMPLOYER ______________________________________WORK PHONE______________

PERSON TO CONTACT IN EMERGENCY______________________REL. TO PATIENT____________
EMPLOYER_________________HOME PHONE__________________WORK PHONE____________

Has the patient or any immediate family member been seen at this office before? Yes No

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PERSON RESPONSIBLE FOR BILL (if different from patient)

NAME____ HOME PHONE: (____)____________

ADDRESS____
street city state zip

EMPLOYER____WK PH: ______________

SOCIAL SECURITY #_______________________RELATIONSHIP TO PATIENT__________________

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

FATHER'S NAME__________________________________FATHER'S SS#____________________

MOTHER'S NAME_________________________________MOTHER'S SS#____________________

Father's place of Employment____________________________Work Phone #____________________

Mother's place of Employment___________________________Work Phone #____________________

PRIMARY INSURANCE CO.____

Policy Holder's Name____Date of Birth________________

Social Security #______________________Policy #____________________Group #________________

SECONDARY INSURANCE CO.____

Policy Holder's Name____Date of Birth________________

Social Security #______________________Policy #____________________Group #________________

If patient is a college student: _____full time _____ part-time School Name________________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail, or FAX.. 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. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

I understand that if my insurance denies payment or if I have no insurance coverage, that I am financially responsible. I understand that payment is due at the time of my visit unless previous financial arrangements have been made with The Raleigh Eye Center, P.A.. Many insurance companies, including Medicare, DO NOT pay for eye refractions (testing performed to determine glasses or contact lens prescriptions). The patient will be responsible for this charge if not covered by insurance.

X____ DATE __________________

Patient or Legal Guardian

Acknowledgement of Receipt of Privacy Practices

I have received or reviewed a copy of the Notice of Privacy Practices for The Raleigh Eye Center, P.A.

X____ DATE __________________

Patient or Legal Guardian

**********************OFFICE USE ONLY**************************

PRIMARY INSURANCE CARD **SECONDARY INSURANCE CARD**