

PATIENT INFORMATION

Date _____
Patient Name _____ Age _____ Birthdate _____
Sex _____ M _____ F _____ Single _____ Married _____ Widowed _____ Divorced
Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ SS# _____
Employer _____ Occupation _____
Employer Address _____

Spouse's Name _____ Spouse's Employer _____
Spouse's SS# _____ Spouse's Birthdate _____

Person Legally Responsible _____ Relationship _____
(if other than self)
Address _____ Home Phone _____
Employer _____ Business Phone _____

Notify in Case of Emergency _____ Relationship _____
Address _____ Phone _____

Referred by _____ Medical Doctor _____

INSURANCE INFORMATION

Please allow us to photocopy your cards for our records

Primary Ins. Name and Address _____
SS# of the insured _____ Birthdate of the insured _____

Secondary Ins. Name and Address _____
SS# of the insured _____ Birthdate of the insured _____

I hereby authorize Parkwood Eye Center to treat me as a patient. Additionally, they may release necessary information to my insurance carriers in the event a claim is made. I assign to the doctors all payments for medical services rendered to myself or my dependents. I understand that I am personally responsible for this account and that payment is expected when services are rendered unless other arrangements have been made in advance.

Signature of Patient or Guardian _____ (seal)