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 ______________________________