PATIENT INFORMATION

Date_____

Patient Name_____ **Age**_____ **Birthdate**_____

Sex M____ **F**____ **Single**____ **Married**____ **Widowed**____ **Divorced**____

Address_____**City**_____ **State**_____ **Zip**_____

Home Ph._____ **Business Ph.**_____ **Cell Ph.**_____ **SS#**_____

E-Mail Address_____

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)**