SOUTHERN EYE GROUP

PATIENT INFORMATION

Name ______________________________

Address ______________________________

City ______________ State ____ Zip ________

Phone # (   ) ______________________

Cell # (   ) ______________________

Email ______________________________

How did you hear about us? __________________

Referring Doctor ______________________

Primary Care Physician __________________

Social Security # ______________________

Date of Birth ______________ Age ________

Gender: Male Female

Race: ______________________________

Ethnicity: ______________________________

Language: ______________________________

Marital Status: Single Married Widowed Divorced

Emergency Contact ______________________

Emergency Phone # (   ) ________________

Relationship ______________________________

Are you employed? Yes/Where? __________ No Retired

INSURANCE INFORMATION

Primary Insurance Co ______________________

Policy Holder Name ______________________

Policy # ______________Policy Holder DOB ______

Secondary Insurance Co ______________________

Policy Holder Name ______________________

Policy # ______________Policy Holder DOB ______

Vision Insurance Co ______________________ Policy Holder Name ______________________

Last 4 Digits of Policy Holder SSN ______________ Policy Holder DOB ____________

RESPONSIBLE PARTY

- I authorize and consent to the professional services rendered to the above patient. Authorization is given to release information as may be necessary for the completion of medical insurance claims, the benefits of which may be assigned to the physician at his option.
- I agree to pay interest on any uncollected amount of debt to **Bay Eyes Cataract & Laser Center, P.C.** I agree to pay the cost of collection for past due debt. I acknowledge responsibility for the payment of services rendered and agree to pay for them at the time of service. Co-pays, fitting fees, and refractions not covered by insurance will be paid at the time of service.
- By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and healthcare operations. You may refuse to share your information.
- You should read the Notice of Privacy Policies for PHI located at the front desk or the lobby copy provided at the doctor's office before you sign the consent form. If you would like a personal copy, please ask the front desk receptionist. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer of this practice.
- You have the right to request that this practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. This practice is not required to agree to requested restrictions; however, if the practice does agree to your requested restrictions, the restriction is binding on it.
- Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
- You may communicate with the following individual(s) regarding my condition or course of treatment(s):

  ____

- You may communicate confidential information to me at the address and phone numbers listed above or at the following:

  ____

Patient Signature (or Responsible Party) ______________________________ **Date** ______________