ESTERMAN EYE INSTITUTE OPHTHALMOLOGY

PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME:_____ MI: ____ DOB:____/____/_____

LOCAL ADDRESS: _____ CITY:_____ STATE: ____ ZIP_____

PHONE NUMBER: Home:_____ Cell:_____ EMAIL:_____

SEX: MALE / FEMALE SOC. SECURITY #: _____-_____-_____ MARITAL STATUS: S / M / D / W

EMERGENCY CONTACT: _____ PHONE #:_____ RELATIONSHIP:_____

PHARMACY:_____ PHONE #:_____ Occupation:_____

EMPLOYER:_____PHONE #:_____ UNEMPLOYED / STUDENT / RETIRED

IF LIABLILTY - DATE OF INJURY:_____/_____/_____ ☐ WORK-RELATED ☐ MOTOR VEHICLE ☐ OTHER ☐ N/A

RESPONSIBLE PARTY INFORMATION *(if other than Patient)*:

LAST NAME: _____ FIRST NAME:_____ MI: ____ DOB:____/____/_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP_____

PHONE NUMBER: Home:_____ Cell:_____ Work:_____

RELATIONSHIP: _____ SOC SECURITY #: _____-_____-_____

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance carrier to make payments directly to ESTERMAN EYE INSTITUTE on my behalf.

FINANCIAL AGREEMENT: As a courtesy to our patients, we will submit to Medicare and other insurances for you. However, this does not relieve your financial responsibility for deductibles and coinsurance amounts. Claims denied by your insurance carriers will be your responsibility. Medicare does not pay all health care costs. Medicare only pays for covered benefits, NOT "Vision Services".

PATIENT'S RIGHTS and DISCLOSURES: In general, the HIPPA privacy rule gives the individual the right to request restrictions on uses and disclosure of health information. The individual is also provided the right to request confidential communications of health information be made by an alternative means. We are dedicated to maintaining the privacy of your personal information

At ESTERMAN EYE INSTITUTE, it is our goal to provide the highest level of professional medical care to our patients. If you have any questions pertaining to any of the above, please feel free to ask our staff.

I agree that all the information given is accurate and that I have read all information included in this form.

Sign: _____ Date: _____/_____/_____