PATIENT DATA SHEET

Date _____ Emp. Initials _____

NAME: LAST _____ FIRST _____ MI _____ AGE _____ SEX: M/F

PREFERRED NAME:_____ HOME PHONE_____

BIRTH DATE _____/____/_____ CELL PHONE: _____

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____ SSN _____ - ___ - _____

E-MAIL ADDRESS: _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE_____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: SINGLE WIDOWED DIVORCED MARRIED SPOUSE: _____

SPOUSE'S EMPLOYER: _____

Insured/Patient information

PRIMARY INSURANCE _____ PHONE NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

INSURED'S EMPLOYER_____ PHONE _____

DATE OF BIRTH _____ SSN _____ - ___ - _____

PRIMARY PHYSICIAN _____ PHONE_____

SECONDARY INSURANCE _____ PHONE_____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

DATE OF BIRTH _____ SSN _____ - ___ - _____ WORK PHONE_____

IF PATIENT IS A CHILD, ALL INFORMATION BELOW MUST BE COMPLETED

PARENT/GUARDIAN NAME_____

ADDRESS_____ APT# _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ DATE OF BIRTH _____

PARENT SSN _____ - ___ - _____ EMPLOYER_____

SPOUSE'S NAME _____ WORK PHONE_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

EMERGENCY CONTACT (FAMILY, CLOSE FRIEND, NEIGHBOR):
NAME _____ **PHONE**_____
ADDRESS _____**CITY** _____ **ZIP**_____
CLOSEST RELATIVE NOT LIVING WITH YOU:
NAME _____ **PHONE**_____
ADDRESS _____**CITY** _____ **ZIP** _____

*******INSURANCE INFORMATION*******

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I hereby assign any and all payment of benefits to Sighttrust eye institute, upon their acceptance of assignment. A photocopy of this release/assignment of benefits is to be considered as valid as an original. In addition, **I understand that my signature below constitutes a once in a lifetime signature on file.**

Payment or co-payment is expected at time of service. We accept cash, checks, visa, MasterCard, or American Express. We can arrange a payment plan in some cases, but they must be made in advance**.**

If your account is placed with a collection agency, you will be charged all costs relating to collecting this account (collection fees, court costs, atty. fees, etc.)

You are responsible for: Any unmet deductibles - non-covered services - all charges not paid by insurance.

IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN REFERRALS FROM PRIMARY CARE PHYSICIANS, IF REQUIRED, AND TO KEEP INSURANCE INFORMATION UP TO DATE.

In filing your insurance claims, remember, however that your insurance contract is between you and the insurance company. The final responsibility for your bill is with you. If your insurance company does not pay within 60 days, or your coverage has terminated prior to services being rendered, you will be responsible for payment of these services at our customary rates.

I hereby consent to the examination and treatment as deemed necessary by physicians of Sighttrust eye institute. I have read (or had read to me) the above information and have a full understanding of its meanings.

I give consent for the following: (Circle one)

Messages left at home: Yes No / At work: Yes No
E-mail messages: Yes No
Mail regarding personal health information: Yes No

I HAVE READ OR HAVE BEEN OFFERED THE OPPORTUNITY TO READ THE "NOTICE OF PRIVACY PRACTICE".

***** PLEASE GIVE 24HOUR NOTICE WHEN CANCELLING AN APPOINTMENT*****

_____ _____
SIGNATURE **DATE**