

**THE CENTER FOR EYE CARE**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Soc Sec Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Apt Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Home Ph: \_\_\_\_\_ Cell/Other Ph: \_\_\_\_\_

Employment: \_\_\_\_\_ Work Ph: \_\_\_\_\_

Best Time and Place to Reach You: \_\_\_\_\_ Email address: \_\_\_\_\_

Referred: Radio Yellow Pages TV Newspaper Friend Screening Other \_\_\_\_\_

**Information for Insured Party:**

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Soc Sec Number:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Information for Spouse / Parent / Guarantor: (Circle One)**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell/Other Ph: \_\_\_\_\_

**In Case of Emergency, contact (Specify someone who does not live in your house)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell/Other Ph: \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependent(s) have insurance with \_\_\_\_\_ and assign directly The Center for Eye Care all insurance benefits (including Medicare, Medicaid, and/or Medigap benefits, if applicable) otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. To the extent permitted by law, The Center for Eye Care may use my health care information and may disclose such information to the above named Insurance Company(ies) (including Medicare, Medicaid, and/or Medigap benefits, if applicable) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

**THE CENTER FOR EYE CARE**

I, \_\_\_\_\_ hereby authorize the physicians and the staff of **The Center for Eye Care**, to give the following people information concerning my health and well being.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

The following information may be given to the above individuals:

\_\_\_\_\_ Appointment Time

\_\_\_\_\_ Medications

\_\_\_\_\_ Procedures

\_\_\_\_\_ Test/Lab results

\_\_\_\_\_ Billing/Finance Information

\_\_\_\_\_ Any other information regarding my health

I also authorize **The Center for Eye Care** to leave a message on my answering machine or voicemail Regarding upcoming appointments

\_\_\_\_\_ Yes

\_\_\_\_\_ No

I understand that I may revoke this consent at any time by giving written notice to **The Center for Eye Care**. I have been informed of the Notice of Privacy Practices for **The Center for Eye Care** and acknowledge that it is my right to keep a copy of it for my records.

\_\_\_\_\_  
Signature of Patient / Parent / Legal Guardian

\_\_\_\_\_  
Date