



# Tampa Eye Clinic

## PATIENT INFORMATION

2009

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Dr. Creighton | <input type="checkbox"/> Dr. Scheiner |
| <input type="checkbox"/> Dr. Seeley    | <input type="checkbox"/> Dr. Orlick   |
| <input type="checkbox"/> Dr. Reynolds  | <input type="checkbox"/> Dr. Nogales  |
| <input type="checkbox"/> Dr. Leach     | <input type="checkbox"/> Dr. Kasper   |
| <input type="checkbox"/> Dr. Lorenzen  | <input type="checkbox"/> Dr. Pravak   |

PLEASE PRINT CLEARLY

PATIENT NAME: LAST		FIRST		MIDDLE
MAILING ADDRESS: STREET/PO# _____				
CITY: _____		STATE: _____	ZIP: _____	
E-Mail Address: _____				
HOME PHONE: _____	SEX: <input type="checkbox"/> MALE	MARITAL <input type="checkbox"/> MARRIED	DATE OF BIRTH: _____	
CELL PHONE: _____	<input type="checkbox"/> FEMALE	STATUS: <input type="checkbox"/> SINGLE		
SOCIAL SECURITY #: _____		DRIVERS LICENSE: <i>Please allow staff to copy to place in your records</i>		
NAME & TELEPHONE NUMBER OF PARENT OR GUARDIAN: <i>(if applicable)</i>				
OCCUPATION: <input type="checkbox"/> EMPLOYED <input type="checkbox"/> HOMEMAKER <input type="checkbox"/> CHILD/STUDENT <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> OTHER				
CO. NAME: _____		PHONE: _____		
PRIMARY CARE PHYSICIAN: _____		PHONE: _____		
HOW DID YOU FIND OUT ABOUT THE TAMPA EYE CLINIC? <i>(please check one)</i>				
<input type="checkbox"/> INSURANCE CO. <input type="checkbox"/> FRIEND/RELATIVE <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> ADVERTISEMENT <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> EYE SCREENING				
<input type="checkbox"/> MEDICAL DOCTOR <i>(Name):</i> _____ <input type="checkbox"/> OTHER: <i>(please specify)</i> _____				
IS THIS A WORKERS' COMPENSATION VISIT? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF ACCIDENT: _____				
WHOM TO NOTIFY IN AN EMERGENCY? <i>(Nearest relative not living with you)</i>				
NAME: _____		RELATIONSHIP: _____		
ADDRESS: _____				
HOME PHONE: _____		WORK PHONE: _____		
PRIMARY INSURANCE INFORMATION:				
NAME OF INSURANCE COMPANY: _____				
ADDRESS: _____				
ACCOUNT #: _____		GROUP #: _____		
POLICYHOLDER: _____		RELATIONSHIP TO PATIENT: _____		
POLICYHOLDER SS#: _____		POLICYHOLDER DATE OF BIRTH: _____		
SECONDARY INSURANCE INFORMATION:				
NAME OF INSURANCE COMPANY: _____				
ADDRESS: _____				
ACCOUNT #: _____		GROUP #: _____		
POLICYHOLDER: _____		RELATIONSHIP TO PATIENT: _____		
POLICYHOLDER SS#: _____		POLICYHOLDER DATE OF BIRTH: _____		

**ASSIGNMENT & RELEASE:**

I give my permission for the Tampa Eye Clinic to: 1) Release to the Social Security Administration or other insurance carriers, information concerning my insurance claim; and, 2) In the event that the Tampa Eye Clinic chooses to accept assignment, I hereby authorize my insurance company to pay directly to them all medical benefits due me under this policy. I understand that my consent is good for all services and I am responsible for any unpaid balance not paid by my insurance company. **I certify that all the information I have given is correct**, and I have complete authority to execute this document on behalf of myself or patient.

I also understand that payment is expected at the time services are rendered.

SIGNATURE

DATE