



# Tampa Eye Clinic

## PATIENT INFORMATION

2010-A

- |  |                                       |
|--|---------------------------------------|
| <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**

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

**FINANCIAL ASSIGNMENT AND AGREEMENT:**

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier information needed to determine these benefits and to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance and should I default on my account, all attorney fees, interest, and collection costs are my responsibility.

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

SIGNATURE

DATE