Patient Information Form

Last Name	First Name	MI	DOB	Today's Date

Mailing Address	City County	State	ZIP Code

Home phone # Cell phone #	Work Phone (Ext)	Preferred method for your next appointment reminder ☐Text ☐E-mail ☐Phone Call	Social Security # Marital Status ☐Single ☐Married ☐Divorced

Email:

Secondary Address & Phone Number (if applicable)

Emergency Contact: _____

Phone # _____

Race ☐Black/African American ☐American Indian/Alaska Native ☐Asian ☐White ☐Native Hawaiian or Pacific Islands ☐Patient Declined

Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Chinese ☐Filipino ☐Japanese ☐Multi-Racial ☐Other

How did you hear about our practice?

☐Facebook ☐Website ☐Newspaper ☐Radio ☐Patient of Eye Care ☐School ☐Prior Patient ☐Physician:

Insurance information

Primary Insurance Name		Secondary Insurance Name	
Subscriber's Name	**Subscriber DOB**	**Subscriber's Name**	**Subscriber DOB**
Subscriber's ID No.	**Group No.**	**Subscriber's ID No.**	**Group No.**
Patient's Relation to Subscriber ☐Self ☐Spouse ☐Child ☐Other		**Patient's Relation to Subscriber** ☐Self ☐Spouse ☐Child ☐Other	

Please provide the following information so we may improve patient care

Primary Care Physician:
Address:
Phone Number:

Drug Store/Pharmacy:
Address:
Phone Number:

Patient Employment: ☐Employed ☐Retired ☐Unemployed ☐Other **Occupation:** _____
Employer Name: **Address:** **Phone:**

Patient Guarantor

Guarantor: ☐Self **Name:** **SSN:** **Date of Birth**
Phone # **Address:** **City/State/Zip**

Release of Information From Eye Care for the Adirondacks & Authorization for Payment of Insurance

I give permission for Eye care for the Adirondacks to communicate any, all or summary of findings pertinent to the overall management of my health to my Primary Care Physician. Additionally these Secondary Providers, Specialty, School or other:
Names: _____

I request that payment of authorized Medicare and/or my insurance benefits be made on my behalf of Eye Care for the Adirondacks for any services furnished to me by any physician or provider of that organization. I authorize Eye Care for the Adirondacks to release medical information about me as necessary to the Health Financing Administration and/or my insurance carrier in order to determine these benefits payable for related services.

I understand that I am finacially responsible for any balances my insurance carrier doesn't pay. If insurance is not involved, I agree to pay at the time of service unless other arrangements have been made.

Signature of Patient/Parent/Guardian: _____ **Date:** _____