PATIENT INFORMATION

Date: _____

Patient's Name: _____ **Email Address:** _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: ( ) _____ Work#: ( ) _____ Date of Birth: _____

Cell Phone #: ( ) _____ Can we text you? Y____ N____

Social Security #: _____ Circle Sex: M F Marital Status: _____

Race: _____ **Language:** _____ **Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Unknown

Smoking Status: ☐ Current everyday smoker ☐ Current someday smoker ☐ Current status unknown ☐ Former smoker
☐ Never smoked ☐ Unknown if ever smoked **Diabetic:** Y____ N____

Patient's Employer: _____ Occupation: _____

Contact In Case of Emergency: _____ Phone #: _____

Primary Care Doctor: _____ Referring Doctor: _____

Insurance Information: Is vision coverage included with this policy? ☐ Yes ☐ No

Primary Insurance Co. _____ Phone #: _____

Insured Name: _____ Relation to Patient: _____

Insured Policy ID #: _____ PT Policy ID #: _____ Group #: _____

Insured DOB: _____ Insured SS #: _____ Ins. Employer: _____ Emp. Phone #: _____

Secondary Insurance Co.: _____

Insured Name: _____ Relation to Patient: _____

Insured Policy ID #: _____ PT Policy ID #: _____ Group #: _____

Insured DOB: _____ Insured Employer: _____ Employer Phone #: _____

If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other: _____

DO YOU HAVE SEPARATE VISION COVERAGE? ☐ Yes ☐ No

Name of vision carrier: _____

Name of insured: _____ Insured Date of Birth: _____ Relation to Patient: _____

IS THIS A WORKER'S COMPENSATION INJURY? ☐ Yes ☐ No

Employer at time of injury: _____ Claim #: _____ Date of Injury: _____

IF PATIENT IS A MINOR:

Mother's Name: _____ Date of Birth: _____ Phone: _____

Mother's Employer: _____ SS #: _____ Bus. Phone: _____

Father's Name _____ Date of Birth: _____ Phone: _____

Father's Employer: _____ SS #: _____ Bus. Phone: _____

CONSENT FOR TREATMENT:

I understand that medical treatment may be necessary and I hereby consent to authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgement of the physician. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of my examination, care, and treatment.

RELEASE OF INFORMATION:

I hereby authorize my physician and Apex Eye to release any information acquired in the course of my examination or treatment to insurance carriers, 3rd party payers, Health Care Financing Administration and it's agents or others requesting information needed to determine benefits.

PAYMENT IS REQUESTED AT THE TIME OF SERVICE:

I have read and understand the Apex Eye FINANCIAL AGREEMENT.

I acknowledge that I am responsible for payment to Apex Eye for services rendered. I hereby authorize that benefits from insurance carriers be paid directly to Apex Eye or my physician. I am financially responsible for any non-coverage services. I further request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to my physician for any services furnished by my physician.

Date: _____ Signed: _____