SIGHT
EYE CLINIC, P.C.
EYE CARE & SURGERY

PATIENT INFORMATION

TODAY'S DATE:

LAST NAME: **FIRST NAME:** **M.I.**

BIRTHDATE: **MALE** **FEMALE**

STREET ADDRESS: **CITY:** **STATE:** **ZIP:**

RACE: (circle one) Caucasian Asian African American Hispanic Other DECLINE

PREFERRED LANGUAGE: (circle one) English Spanish Other:

ETHNICITY: (circle one) Hispanic/Latino NOT Hispanic/Latino Unknown DECLINE

MARITAL STATUS: (circle one) Married Widowed Single Divorced

PREFERRED PHONE #: **ALTERNATE PHONE #:**

EMAIL ADDRESS:

PRIMARY CARE PHYSICIAN: **REFERRING DOCTOR:**

IN HOSPICE CARE? (end of life) Yes No

FINANCIAL INFORMATION

Please fill out all insurances that apply

PRIMARY MEDICAL INSURANCE: (will be billed if exam has a medical diagnosis) **EMPLOYER:**

SUBSCRIBER NAME: (If other than patient) **SUBSCRIBER BIRTHDATE:**

SUBSCRIBER ADDRESS: (if different than above)

SECONDARY MEDICAL INSURANCE:

SUBSCRIBER NAME: (If other than patient)

SUBSCRIBER BIRTHDATE:

PRIMARY VISION INSURANCE: (for routine eye exam, glasses, or contacts)

SUBSCRIBER NAME: (If other than patient)

SUBSCRIBER BIRTHDATE:

FINANCIAL RESPONSIBILITY WAIVER OF LIABILITY - SIGHT EYE CLINIC, P.C.

I understand that some services such as refractions, routine examinations, screening examinations and charges for contact lens and glasses provided to me may not be covered under Medicare and insurance guidelines. I have read and understand this statement and choose to accept those services.

I understand and accept full responsibility for all charges, whether or not paid by Medicare, private insurance or any other insurance plan. In the event this account is assigned to collection, I agree to pay a one-time fee of 50% of the bill.

I authorize and assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Sight Eye Clinic, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I further authorize said assignee to release all information necessary to secure payment.

X _____

Signature of Patient

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

X _____

Signature of Patient

(Employee signature) _____

Witness

PRIVATE PARTY BILLING AND MEDICAL INFORMATION RELEASE

I give permission for Sight Eye Clinic, P.C. to release my (or my child's) medical and/or billing information to the following person(s):
(Please print)

1. In Case of Emergency: _____ Relationship to patient: _____

Phone Number: ( ) _____

2. Name: _____ Relationship to patient: _____

3. Name: _____ Relationship to patient: _____

X _____ **X** _____

Signed **Date**

Thank you for choosing the Sight Eye Clinic for your vision and health needs. Since we are committed to providing you with the highest standard of care, we kindly ask our patients to update this form on an **annual** basis.

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