center for sight
keeping your world in focus

Patient Information

Date: _____

Patient Name: _____ _____ _____
(last) (first) (middle initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
(month) (day) (year)

Gender: M F Race: _____ Ethnicity: _____ Preferred Language: _____

Preferred Contact Method

Email Address: _____ ☐

Primary Telephone: _____ - _____ - _____ Home Cell ☐

2nd Telephone: _____ - _____ - _____ Home Cell ☐

Martial Status _____

Do we have your permission to speak with your spouse or partner regarding your medical care? Yes No

Spouse or Partner's Name: _____

I hereby authorize Center for Sight and its staff to leave a message on the telephone numbers I have given regarding appointments.

_____ Date: _____
Signature of Patient – If patient is a minor Parent /guardian

INSURANCE INFORMATION:

Primary Insurance: _____ Policy Number: _____

Subscriber Name & Date of Birth: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Employer: _____ Occupation: _____

Secondary Insurance: _____ Policy Number: _____

Subscriber Name & Date of Birth: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Is this claim covered under Worker's Compensation Yes ___ No ___

If yes, Name of Insurance: _____ Date of Injury: _____

Insurance Address: _____

Insurance Telephone: _____ Adjustor's Name: _____

Claim # _____

Referred By: Doctor _____ Web Mail Radio Other _____

Doctor's Address: _____ Telephone: _____

PCP: _____ Telephone: _____

If patient is a minor, parental/guardian contact information:

Parent/Guardian's Name: _____ Date of Birth: _____ / _____ / _____

Address: Same as patient ___ or _____

Social Security Number: _____ - _____ - _____

Primary Telephone: _____ - _____ - _____ _ Home Cell

2nd Telephone: _____ - _____ - _____ Home Cell

FINANCIAL AUTHORIZATION

I hereby authorize the insurance companies to make payment directly to Center For sight for medical and/or surgical benefits.

I hereby authorize Center For Sight to release any medical information necessary to process medical and/or surgical claims.

I understand that, even though I have insurance coverage there are some services and charges, such as co-payments and deductibles that are not covered and I will be financially responsible for these charges.

_____ Date: _____

Signature of Patient or Parent/Guardian