WHITE EYE ASSOCIATES PA
OPHTHALMOLOGY

Patient Information

Complete all blanks

FOR OFFICE USE ONLY

MRN _____

Date _____

Patient Name _____
Last First Middle

Social Security # _____/_____/_____ Date of Birth _____ /_____ /_____ Sex M / F
MM DD YYYY Circle

Address _____ City _____

State _____ Zip _____ Race _____ Language _____

Home Phone ( ) _____ Day/Cell Phone ( ) _____

Emergency Contact Name _____

Relationship to patient _____ Contact/AlternatePhone ( ) _____

Patient's Employer _____ Work Phone ( ) _____

Person Responsible for Payment _____ Relationship _____

Primary Insurance Company _____

Policyholder Name _____ Policyholder Date of Birth _____/_____/_____
MM DD YYYY

ID # _____ Group # _____ Relationship to Policy Holder _____

Secondary Insurance Company _____

Policyholder Name _____ Policyholder Date of Birth _____/_____/_____
MM DD YYYY

ID # _____ Group # _____ Relationship to Policy Holder _____

How Did You Hear About Our Practice? ❑ Friend/Relative ❑ Yellow Pages in Phone Book

❑ Physician Referral _____
Name of Doctor Location

❑ Other _____

Name of Primary Care Doctor _____ Phone ( ) _____

Name of Pharmacy _____

Pharmacy Phone ( ) _____ and/or Location _____

Please Complete Reverse Side

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your home answering machine/voice mail/family member?	YES	NO
Leave a message at your place of employment?	YES	NO
Discuss your medical condition(s) witha family member/ member of your household/friend/other? if yes, Whom:_____ Relation:_____	YES	NO
Discuss your medical billing or insurance information with a family member/ member of your household/friend/other? If yes, Whom:_____ Relation:_____	YES	NO

I hereby authorize the processing of the medical insurance either by electronic or manual method by White Eye Associates. My signature authorizes payment of all major medical and /or surgical benefits to which I am entitled from the listed insurer to pay to White Eye Associates. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

HIPAA: I hereby give my consent for White Eye Associates to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations.
I have received and read the **NOTICE OF PRIVACY PRACTICES** prior to signing this consent.

_____ _____

Patient or Guardian's Signature Date

_____

Relationship to Patient