PATIENT INFORMATION

Date of Service_____ Appt Time_____ **Dr. N** **Dr. W** **Dr. A** **Dr. F**

Reason for visit today_____

Name_____ Nickname_____ Gender M or F
First Mi Last

DOB:_____ Race**:** _____Preferred Language ___English ___Spanish Marital Status: S M W D

SS#:_____Ethnicity: ___Hispanic or Latino ___ Native Hawaiian/Other Pacific Island ___Not Hispanic or Latino

Address_____City_____State_____Zip Code_____

Home ( ) _____Work ( ) _____Cell ( ) _____

E-mail address_____

Employer/School_____Occupation/Grade_____

Responsible Party Name (for 18 years and under)_____DOB_____

SS#_____ Relationship to Patient_____

ROUTINE VISION PLAN NAME AND ID #: _____

Primary Insurance_____ Member ID#_____

Subscriber Name_____DOB_____SS#_____

Relationship to Patient_____ *** Medical DX required ***

Secondary Insurance_____ Member ID#_____

Subscriber Name_____DOB_____SS#_____

Relationship to Patient_____

The patient is personally responsible for payment for all services. As a courtesy, we will assist in making collections from insurance companies and will credit as such collections to the patient's account.
PAYMENT AUTHORIZATION- I hereby authorize Pee Dee Eye Associates, PA to furnish information concerning my present illness. I direct the insurer to pay directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all out of network charges, co-payments, co-insurance, deductibles, and any services not covered (including 92015 Refraction) by my insurance at the time of service. A copy of this authorization will be valid as the original.

SIGNATURE OF PATIENT_____DATE_____ **SEE OTHER SIDE** ===

FOR OFFICE USE ONLY

RECALL / NEXT APPT _____ DAY WEEK MONTH YEAR

__FULL EXAM __DILATE __ GLAUCOMA __VF __ CL CHECK __ F/U SHORT __ F/U LONG

__ LASIK CK __LV EXAM ___ LV F/U Notes:_____