Cabarrus Eye Center

Referred by: ____Physician _____Friend _____Advertising ____Yellow Pages Other_____

Patient Information

Name _____
Last First Middle/Maiden

Social Security Number _____

Address (Residence)

_____

_____

Mailing Address (if different)

_____

_____

Email:_____

Date of Birth _____ Sex: M _____ F_____

Marital Status: □single □married □divorced □widow

Phone Number(s) H: _____

Daytime #: _____

Employer:_____

Referring Physician:_____

Primary Care Physician:_____

Responsible Party

(Must be 18 or older and legally responsible for patient)

___ I am my own responsible party.

Name _____
Last First Middle/Maiden

Address (Residence)

_____

_____

Mailing Address (if different)

_____

_____

Employer Address

_____

_____

Relationship to Patient: _____

Emergency Contact

Name _____

Phone Number _____

Address _____

_____

May we disclose pertinent medical information about you to this emergency contact person? ___YES ___NO

Please list any other individuals you permit us to discuss your protected health information with.

_____ _____ _____ _____

Insurance Information

___ I will be paying for today's visit myself. ___ Today's visit will be a worker's comp claim.

Primary Insurance Company_____ ___ I am the policy holder

Policy Holder's Full Name _____

Social Security # _____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

Secondary Insurance Company_____ ___ I am the policy holder

Policy Holder's Full Name _____

Social Security # _____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

Please read and initial by each statement, indicating your agreement.

__ By signing below, you acknowledge that you received/reviewed a copy of the HIPPA Notice of Privacy Practices for Cabarrus Eye Center, P.A. and Eye Surgery and Laser Clinic, P.A. (available at the front desk.) The Notice explains how your medical information can be used and disclosed and how you can access that information. We encourage you to read it. If you have any questions, please ask.

__ All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is solely responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I have presented myself for treatment to the physicians of Cabarrus Eye Center, P.A. and hereby authorize these physicians to perform the necessary examinations and procedures that are medically necessary for my treatment. I understand that these services may or may not be covered by my insurance plan, and I will be responsible for payment of any charges my insurance plan does not cover.

__ I have authorized the release of any information acquired in the course of my examination or treatment and authorize payment directly to the physician. I also permit a copy of this authorization to be used in place of the original.

Signature:_____ Date_____