

# Patient Paperwork



## Personal Information

Full Name:		Social Security Number:
Physical Address (No PO Box):		
City:	State & Zip:	Home #:
Cell #:	Email:	
Communication Preference: <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email	Primary Language:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	

## Account Responsible Information

Full Name:		
Cell #:	Work #:	DoB:
Address:		SSN:
Relationship to Patient:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

## Insurance Information Please check here if the policy holder is the same as Account Responsible

Policy Holder's Full Name:		
Cell #:	Work #:	DOB:
Address:		SSN:
Relationship to Patient:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insurance Company:		
Contract #:	Group #:	

## Current Medications

Is there any family history of Cancer, Diabetes, Glaucoma, and/or Macular Degeneration? if so, which family member(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes

Allergies to any medication(s)? If so, please list:  No  Yes

Primary Care Physician and Location:

Preferred Pharmacy and Location:

**Medical Release & Financial Responsibility information:**

I request that payment of my insurance benefits be made on my behalf to Basden Eyecare for services rendered by any of our doctors. I authorize any holder of medical information about me released to process my claims. I understand my signature requests that payment be made to Basden Eyecare. My signature also authorizes the **release of medical information** necessary to pay the claim if any of their offices at the time the services are rendered or at a later date if I am billed.

I understand that I am **financially responsible for any charges** whether or not paid by my insurance company. I agree by signing this that I will be responsible for any late charges incurred because my account is past due. I also agree that I will be responsible for any collection charges (based on the amount charged by the collection agency) incurred because my account is past due.

As per the law, we must inform you about the legal responsibilities and privacy practices related to your protected health information. This notice contains important details regarding the same. Kindly review it carefully.

I approve the release of information to the following parties:

My Spouse  My Children  My Physician  Legal Guardian  Account Responsible

Name of Parties:

I elect not to release any of my information except what is necessary to process my insurance claims

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_