



## PATIENT DATA SHEET

**Please print or circle the appropriate answer; put N/A if not applicable.**

|   |             |                            |         |             |                 |
|---|-------------|----------------------------|---------|-------------|-----------------|
| Patient Last Name:                                    |             | Patient First Name:        |         |             |                 |
| Street Address:                                       |             |                            |         |             | Middle Initial: |
| City:   | State:      | Zip:                       | E-mail: |             |                 |
| Home Phone:   |             | Work Phone:                |         | Cell Phone: |                 |
| Fax:  | Birth Date: | Age:                       | Sex:    | Female      | Male            |
| Social Security Number:                               |             | Preferred Name (Nickname): |         |             |                 |
| Durable Power of Attorney for Healthcare:(If Applies) |             |                            |         |             |                 |

|                                |             |             |
|--------------------------------|-------------|-------------|
| Emergency Contact Information: |             |             |
| Name:                          | Home Phone: | Cell Phone: |

|                   |        |           |        |  |            |
|-------------------|--------|-----------|--------|--|------------|
| Patient Employer: |        | Location: |        |  |            |
| Address:          |        |           |        |  |            |
| City:             | State: | Zip:      | Phone: |  |            |
| Fax:              |        |           |        |  | Extension: |

|  |             |             |         |             |                 |
|--|-------------|-------------|---------|-------------|-----------------|
| Guarantor Information/ Financial Responsibility Information: |             |             |         |             |                 |
| Last Name:   |             | First Name: |         |             | Middle Initial: |
| Street Address:  |             |             |         |             |                 |
| City:  | State:      | Zip:        | E-mail: |             |                 |
| Home Phone:  |             | Work Phone: |         | Cell Phone: |                 |
| Fax:   | Birth Date: | Sex:        | Female  | Male        |                 |
| Social Security Number:                                      |             |             |         |             |                 |

|                         |           |           |             |           |         |
|-------------------------|-----------|-----------|-------------|-----------|---------|
| Patient Marital Status: | Single    | Married   | Divorced    | Separated | Widowed |
| Patient Student Status: | Full Time | Part Time | Non-Student |           |         |

|  |  |           |
|--|--|-----------|
| Primary Care Physician:  |  |           |
| Name:  |  | Phone:    |
| Address:   |  |           |
| May we leave a message on an answering machine/voice mail?   |  | Yes    No |
| May we leave a message with another individual if you are not available?                                     |  | Yes    No |
| Whom may we thank for this referral?   |  |           |
| Have you had a recent hospitalization that caused you to spend time in any form of skilled nursing facility? |  | Yes    No |



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|                          |             |  |        |                  |
|--------------------------|-------------|--|--------|------------------|
| Primary Insurance Name:  |             |  |        |                  |
| Policy Holder Last Name: |             | First Name:  |        | Middle Initial:  |
| Street Address:          |             |  |        |                  |
| City:                    | State:      | Zip:   | E-mail |                  |
| Home Phone:              |             | Work Phone:  |        | Cell Phone:      |
| Fax:                     | Birth Date: |  | Sex:   | Female      Male |
| Social Security Number:  |             | Patient Relation to Insured:      Self      Spouse      Child      Other |        |                  |
| Policy Number:           |             | Group Number:  |        |                  |

|                           |             |  |        |                  |
|---------------------------|-------------|--|--------|------------------|
| Secondary Insurance Name: |             |  |        |                  |
| Policy Holder Last Name:  |             | First Name:  |        | Middle Initial:  |
| Street Address:           |             |  |        |                  |
| City:                     | State:      | Zip:   | E-mail |                  |
| Home Phone:               |             | Work Phone:  |        | Cell Phone:      |
| Fax:                      | Birth Date: |  | Sex:   | Female      Male |
| Social Security Number:   |             | Patient Relation to Insured:      Self      Spouse      Child      Other |        |                  |
| Policy Number:            |             | Group Number:  |        |                  |

|  |             |  |        |                  |
|--|-------------|--|--------|------------------|
| Other Insurance Name: (Eye Insurance Coverage) |             |  |        |                  |
| Policy Holder Last Name:                       |             | First Name:  |        | Middle Initial:  |
| Street Address:                                |             |  |        |                  |
| City:  | State:      | Zip:   | E-mail |                  |
| Home Phone:                                    |             | Work Phone:  |        | Cell Phone:      |
| Fax:   | Birth Date: |  | Sex:   | Female      Male |
| Social Security Number:                        |             | Patient Relation to Insured:      Self      Spouse      Child      Other |        |                  |
| Policy Number:                                 |             | Group Number:  |        |                  |

|   |              |
|---|--------------|
| I consent to the treatment necessary for the care of the above named patient.   |              |
| I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. |              |
| I allow fax transmittal of records if necessary.  |              |
| I authorize and request that insurance payments be made directly to this provider should they elect to receive such payment.      |              |
| I have read and fully understand the above consent for treatment, release of medical information, and insurance authorization.    |              |
| <b>Signature:</b>   | <b>Date:</b> |



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Statement of Financial Responsibility

I hereby assign and authorize benefits for services rendered to me to be paid directly to Woolfson Eye Institute. I understand that verification of insurance benefits is not a guarantee that benefits will be paid.

I further understand that my health insurance company may not cover all or part of the medical services rendered and that I am financially responsible for and agree to pay all charges not paid by my health care coverage.

I understand that Woolfson Eye Institute may file my insurance claim as a courtesy; however I am ultimately responsible for payment for services rendered.

I authorize the release of medical information as may be required to process the claims for payment of the medical services rendered.

A copy of the assignment shall be considered as valid as the original.

**Signature:**

**Date:**

Notice of Privacy Practices Acknowledgement

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notices, the terms may change. If we change our notice you may obtain a copy by writing to our office with your request.

You have the right to request that we restrict how your protected health information is used or released for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do agree, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information as described in our notice. You have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

Patient Name (Print): \_\_\_\_\_

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

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

**Witness:** \_\_\_\_\_