

# Patient Information Form

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

Name: \_\_\_\_\_ Known by any other Name: \_\_\_\_\_  
Last First MI

Birth date: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip County

Billing Address \_\_\_\_\_  
Street City State Zip County

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Which number is best to call you at: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Occupation: \_\_\_\_\_ Emp. Status: FT PT

Employer Address: \_\_\_\_\_  
Street City State Zip County

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

If under 18 => Parent/Guardian's Name: \_\_\_\_\_

## POLICY HOLDER/ INSURANCE

Policyholder: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip County

Primary Insurance: \_\_\_\_\_ Policy No./ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Street City State Zip County

Secondary Insurance: \_\_\_\_\_ Policy No./ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Street City State Zip County

## PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize that payment of authorized insurance benefits be made directly to **AWAD EYE CARE, LLC** for any services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to my Medical Insurance Carrier any information needed to determine the benefits payable for related services for myself and/or my dependents. I also give AWAD EYE CARE, LLC permission to release any records or information needed for continuity of care to the doctor/provider to whom I am being referred.

I permit a copy of this authorization to be used in the place of the original.

**I understand that I am financially responsible for all co-payments, deductibles, or amounts not covered by my insurance carrier.**

**Patient/Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

If guardian, what is your relationship to the patient?: \_\_\_\_\_