PATIENT INFORMATION SHEET

INSURANCE CODE _____ **ACCT #** _____

Today's Date: _____ - _____ - _____

SS# _____/_____/_____ Date of Birth: _____ - _____ - _____

Patient Name: _____

Phone: (____) _____ Work: (____)_____ Cell: (____)_____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Male___ Female___ / Employed___ Retired___ Unemployed___ Student ____

Primary Care Physician: _____

Referred by Dr: _____

Family or Friend: _____

Person responsible for payment: Self _____ Parent _____

Name(s): _____

IF THE PATIENT IS A CHILD, please indicate both parents names above and fill in parent's employment status below.

Name: _____ SS# _____/_____/_____

DOB: _____ - _____ - _____

Employer: _____

Occupation: _____

Address: _____

Work Phone: (____)_____

Spouse's Name: _____

Spouse's DOB: _____ - _____ - _____ SS# _____/_____/_____

Employer: _____

Phone Number: (____)_____

EMERGENCY CONTACT (NOT LIVING WITH YOU): _____

Phone: (____)_____ How Related: _____

Due to HIPAA requirements, we are requesting that you provide a few names of family members or friends with whom we can discuss your personal medical information. ***Thank you.***

1._____ 2._____

3._____ 4._____

Name of Primary Medical Insurance: _____

Secondary Insurance: _____

Vision Plan: _____

1. *I request that payment of authorized Medicare and/or insurance benefits be made on my behalf of Complete EyeCare West for any services furnished me by them. I authorize any holder of medical information about me to release to the Center for Medicare Services, it's agents, or any other insurance carrier I may have, any information needed to determine theses benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. I further acknowledge that I have read the Notice of Privacy Practices for Complete EyeCare West.*
2. *I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if I fail to provide any necessary written referral forms prior to the exam, I will be given the opportunity to pay for the exam(s) today or reschedule the appointment.*
3. *Medicare and most medical insurances companies deny payment for refraction for glasses. I agree to be personally responsible for payment.*
4. *I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.*
5. *I further agree and consent the taking of photographs which my doctor deems necessary for medical treatment information or education purposes.*

Signature _____

Relationship to patient _____ Date _____

Complete EyeCare West
5141 W Broad St.
Ste 100
Columbus, Ohio
43228

phone:
614.878.1571

fax:
614.878.8330

info@compeyewest.com