

# PATIENT INFORMATION

Continued:

**If patient is a minor, please provide the following information:**

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If office visit is due to an accident, please provide the following information:**

Date of injury \_\_\_\_\_

Is injury work related? \_\_\_\_\_ If yes, give supervisor's name \_\_\_\_\_

Was an automobile involved? \_\_\_\_\_ If yes, give location: City \_\_\_\_\_

State \_\_\_\_\_

## Patient Information Release Authorization and Assignment of Insurance Benefits

I authorize The Regional Eye Center to acquire from and to release to my healthcare team and my insurance company(s) any information required for the purposes of healthcare management and for processing medical claims on my behalf. I authorize my insurance company to pay benefits directly to The Regional Eye Center.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Responsibility for Payment of Medical Services

It is my responsibility to notify The Regional Eye Center of any changes in or special requirements of my insurance coverage. I am ultimately responsible for all fees related to my care. The Regional Eye Center will bill me directly for any amounts not paid by my insurance. This includes, but is not limited to, deductibles, co-insurance, and non-covered services. I agree to pay any balance due.

Signature \_\_\_\_\_ Date \_\_\_\_\_