



Patient Information

Please complete this ENTIRE page

Name (First M.I. Last) _____

Date of Birth _____ **Sex (circle) F / M**

Social Security No. _____ - _____ - _____

Mailing Address Street: _____ Apt # _____

City, State, Zip: _____

Primary Phone (used to confirm) () _____ - _____

Alternate Phone () _____ - _____

First Language _____

Email Address _____

Marital Status (circle) Married Divorced Separated Single Widowed

Race (Circle all that apply)	Ethnicity (circle all that apply)	Employment Status (circle one)
White	Hispanic or Latino	Disabled
Asian	Not Hispanic or Latino	Not Employed
Black or African American	Native Hawaiian	Self Employed
Hispanic	Other Pacific Island	Retired
American Indian or Alaska Native		Employed: Full-Time Part-Time
Native Hawaiian/Other Pacific Island		Student: Full-Time Part-Time

Primary Care Physician Information (If you do not have a PCP please check here _____)

Name _____ Phone () _____ - _____

Address _____

Other Eye Care Provider (Ophthalmologist or Optometrist):

Pharmacy Information:

Name _____ Phone () _____ - _____

Address _____

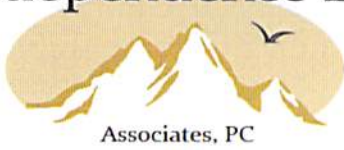
HIPAA and Emergency Contact Information: (A HIPAA contact is someone with whom we may discuss appointments, medications, bills, medical and insurance information, etc.)

Name _____ Phone () _____ - _____

Relation _____

(If you **DO NOT** wish to have above person as a HIPAA contact please check here _____)

How did you hear about us _____



Health Care Coverage Update:

Health care coverage has become extremely complicated and is ever changing. We work with hundreds of patients a week, all with different insurance plans and coverage.

Due to the demands put on our staff regarding this issue we will no longer be addressing any insurance coverage issues in the office.

If you have any question regarding **YOUR** coverage, please call your insurance company and have them explain your plan to you. You should know what is and is not covered, if you need a referral, if you have a deductible to meet, any co payments, or any other out of pocket expenses.

Please remember you chose your health plan and we have no control or responsibility over your coverage.

I understand that my insurance coverage is my responsibility.

If for any reason my insurance company does not pay any claim in full, I acknowledge that I am responsible for all charges that I accrue for any and all exams and/or tests that I have at Independence Eye Associates, now and in the future. Also in the event that any past due medical balance is sent for collection for any reason, I am responsible for any and all legal fees, interest and costs associated with the collection of this matter.

Printed Name: _____

Signature: _____

Date: _____