Independence Eye Associates, PC

# 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**_____

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## 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.

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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:_____