

THOMPSON EYE CLINIC

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Name _____ Today's Date _____
Date of Birth _____
Address _____ SSN _____
City _____ State _____ Zip _____
Check appropriate box: Single Married Divorced Widowed
Mailing Address (if different) _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer (parent's employer if minor) _____
Name of school/college if student _____ City _____
Person to contact in case of emergency _____
Whom may we thank for referring you? _____
E-mail address _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Phone _____
Address _____ Relationship to patient _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? Yes No Date of Birth _____

INSURANCE INFORMATION

Name of Insured Person _____ Date of Birth _____
Address (if different from patient's) _____ Phone _____
Relationship to patient _____ SSN _____
Insured's Employer _____ Work Phone _____

INSURANCE RESPONSIBILITY

We will be glad to check on your insurance policy for you, however due to the number of different insurances, we cannot know the details of every single one. We will be glad to file your claim for you. Please remember that any charge is ultimately the patient's responsibility if the insurance does not cover these charges for any reason.

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.
I hereby authorize evaluation and treatment of my (or my child's) eyecare.

X _____ Date _____
Signature of patient (or parent if monor)