TAMPA EYE CLINIC
Founded 1962

Tampa Eye Clinic
PATIENT INFORMATION

2013

❑ Dr. Creighton ❑ Dr. Scheiner
❑ Dr. Seeley ❑ Dr. Orlick
❑ Dr. Reynolds ❑ Dr. Nogales
❑ Dr. Leach ❑ Dr. Kasper
❑ Dr. Lorenzen ❑ Dr. Patel

PLEASE PRINT CLEARLY

PATIENT NAME:

LAST _____ FIRST _____ MIDDLE _____

MAILING ADDRESS:

STREET / PO# _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

HOME PHONE: _____ **CELL PHONE:** _____

SEX: ❑ FEMALE ❑ MALE

MARITAL STATUS: ❑ MARRIED ❑ SINGLE

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____

SOCIAL SECURITY #: _____ **DRIVERS LICENSE:** *Please allow staff to copy to place in your records* _____

CHECK ALL THAT APPLY:

PREFERRED LANGUAGE:

❑ ENGLISH ❑ SPANISH ❑ OTHER _____

ETHNICITY:

❑ HISPANIC / LATINO ❑ NON-HISPANIC / LATINO ❑ REFUSED / DECLINED

RACE;

❑ AFRICAN / AMERICAN ❑ AMERICAN INDIAN / NATIVE ALASKAN ❑ ASIAN ❑ CAUCASIAN
❑ EUROPEAN ❑ NATIVE HAWAIIAN / PACIFIC ISLANDER ❑ MULTI-RACIAL ❑ REFUSED / DECLINED

NAME OF PARENT OR GUARDIAN: (*(if applicable)* _____ **TELEPHONE NUMBER OF PARENT OR GUARDIAN:** *(if applicable)* _____

OCCUPATION:

❑ EMPLOYED ❑ HOMEMAKER ❑ CHILD/STUDENT ❑ RETIRED ❑ DISABLED ❑ OTHER _____

CO. NAME: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

IS THIS A WORKERS' COMPENSATION VISIT?

❑ YES ❑ NO IF YES, DATE OF ACCIDENT: _____

PLEASE COMPLETE OTHER SIDE ⇨

HOW DID YOU FIND OUT ABOUT THE TAMPA EYE CLINIC? *(please check one)*

❑ INSURANCE CO. ❑ FRIEND/RELATIVE ❑ PHONE BOOK ❑ INTERNET ❑ SIGN ❑ TV/RADIO ❑ EMERGENCY ROOM ❑ EYE SCREENING

❑ MEDICAL DOCTOR *(Name):* _____ ❑ OTHER: *(please specify)* _____

WHOM TO NOTIFY IN AN EMERGENCY? (Nearest relative not living with you)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier information needed to determine these benefits and to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance and should I default on my account, all attorney fees, interest, and collection costs are my responsibility.

I also understand that payment is expected at the time services are rendered.

_____ _____

SIGNATURE **DATE**