



PATIENT INFORMATION

Name _____ Social Security Number _____ - _____ - _____

Birthday ____/____/____ Sex: M / F Marital Status: Single / Married / Divorced / Legally Separated / Widowed

Address _____ City _____ State _____ Zip _____

Phone Number: Home _____ Cell _____ Email _____

Would you be interested in having appointment confirmations sent to you via email or text message? YES / NO

Race: American Indian or Alaskan Native / Asian / Black / White / Unknown Hispanic Origin Not Hispanic Origin

Employer Name _____ Employer Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birthday ____/____/____ Phone # _____

How did you hear about our Practice? _____ Who is your Optometrist _____

Person responsible for bill or legal guardian (Complete only if different from patient) SS# _____ - _____ - _____

Name _____ Birthday ____/____/____ Relationship: _____

Address _____ City _____ State _____ Zip _____ Phone Number _____

Employer Name _____ Employer Number _____

FIRST INSURANCE INFORMATION : Plan Name _____ Effective Date ____/____/____

Address _____ City _____ State _____ Zip _____ Phone _____

Policy Holder _____ SS # _____ - _____ - _____ Birthday ____/____/____

SECOND INSURANCE INFORMATION : Plan Name _____ Effective Date ____/____/____

Address _____ City _____ State _____ Zip _____ Phone _____

Policy Holder _____ SS # _____ - _____ - _____ Birthday ____/____/____

Is your visit due to a job related of automobile accident? YES / NO Is there a Power of Attorney for this patient? YES / NO
If yes, to please notify receptionist.

EMERGENCY contact Name _____ Phone # _____ Relationship _____

I hereby authorize Triad Eye Medical Clinic and other physicians associated with this organization to release any information concerning my care and disease process to my insurance company and other physicians associated with my care. I hereby authorize my insurance company or Medicare to pay directly to Triad Eye Medical Clinic and/or physicians associated with this organization, benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this assignment unless otherwise arranged. I certify that the above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

If minor/parent or legal guardian Signature _____ Date _____