

WELCOME TO TRIAD EYE MEDICAL CLINIC

Thank you for choosing our office. In order to serve you properly we will need the following information.

REFERRAL INFORMATION

Who is your Optometrist? _____ Who referred you to our office? _____

PATIENT INFORMATIONName: _____ Sex M F Birthday / / Age _____

Address: _____ City _____ State _____ Zip _____

Home Phone# () _____ Work Phone# () _____ ext. _____ SS# _____

Race: American Indian or Alaskan Native Asian Black White Unknown Hispanic Origin Not Hispanic OriginMarital Status: Single Married Divorced Legally Separated Widowed Life Partner

Employer Name: _____ If Retired, Former Employer: _____

Employer Address: _____ City _____ State _____ Zip _____

Spouse's Name: _____ DOB: _____ SS# _____

Employer _____ Employer phone: _____

If under the age of 18 please complete the following information:

Parent/Guardian Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone# () _____ Employer _____ Phone # _____

PERSON RESPONSIBLE FOR PAYMENT

Do you have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, How do you intend to pay? <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Cash	Workman's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you belong to an **HMO?** Yes No If yes, do you have an authorization? Authorization # _____ **Secure Horizons** **Pacificare** **Blue Lincs** Others _____ Medicare # _____ Part A Part B Railroad Medicare # _____ Medicaid # _____ Do you have Heartland or SoonerCare? Yes No**PRIMARY INSURANCE INFORMATION**

Insurance Name: _____ Phone# () _____

Address: _____ City _____ State _____ Zip _____

Policy #: _____ Group # _____

Subscriber name _____ SS # _____ DOB _____

Is it through your employer? Yes No**SECONDARY INSURANCE INFORMATION**

Insurance Name: _____ Phone# () _____

Address: _____ City _____ State _____ Zip _____

Policy #: _____ Group # _____

Subscriber name _____ SS # _____ DOB _____

Is it through your employer? Yes No**IN CASE OF EMERGENCY, CONTACT (NOT LIVING IN YOUR HOUSEHOLD)**

Name: _____ Relation _____ Phone# () _____

Address: _____ City _____ State _____ Zip _____

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 _____