



EYE PROFESSIONALS

PATIENT INFORMATION FORM

Thank you for choosing The Eye Professionals.

We are participating in the government's Meaningful Use Requirements Program, which is intended to improve care coordination and ensure security and privacy provisions for personal health information. Please complete this form so we have accurate information about you.

Name: _____ Date of Birth: ____/____/____ Gender: M F

Address _____ City _____ State _____

Zip Code _____ Social Security _____-_____-_____

Phone #'s: (H) ____-____-____ (W) ____-____-____ (C) ____-____-____

Single Married Divorced Widowed

Family Doctor: _____ Phone Number: _____

Referring Doctor: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Pharm Name/City: _____ Pharm Phone# _____

Email Address: _____

Smoking Status:

- | | | |
|---|--|---|
| <input type="checkbox"/> Current, everyday smoker | <input type="checkbox"/> Current, part-time smoker | <input type="checkbox"/> Former smoker |
| <input type="checkbox"/> Never smoked | <input type="checkbox"/> Current status unknown | <input type="checkbox"/> Unknown if ever smoked |

Race:

- | | | |
|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Decline to Answer |

Ethnicity:

- | | | |
|---|---|--|
| <input type="checkbox"/> NOT Hispanic or Latino | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Decline to Answer |
|---|---|--|

Preferred Language: _____

Height: _____ Ft _____ Inches Weight: _____ Blood Pressure _____/_____

Additional Data: HIV MRSA HEP A HEP B HEP C

Please hand your insurance cards to the receptionist with this form.

If you are not the subscriber for your insurance, please provide:

Subscriber Name _____ DOB ____/____/____

Subscriber SS# _____ - _____ - _____ Relationship to Patient _____

If this is a Worker's Compensation Exam, please provide Employer information:

Employer Name _____ Occupation _____

Address _____ City, State, Zip _____

Contact Phone (____) _____ ext _____

Telephone Consumer Protection Act (TCPA)

I/we agree in order for The Eye Professionals, its employees, and/or agents to service our account or to collect monies I may owe that they may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in additional charges. I understand method of contact may include text messages, emails (using any email address I have provided) in the form of pre-recorded/artificial voice messages and/or use of automatic dialing as applicable. I have read this disclosure and agree that The Eye Professionals, its employees and/or agents may contact me/us as described above.

Insurance Authorization and Assignment

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to The Eye Professionals.

Agreement to Pay

I understand that I am financially responsible for charges not covered by assignment, co-insurance charge, deductibles, and non-covered services.

Patient's signature _____ Date _____

(Signature of insured or authorized agent, patient, or parent if minor)

How did you hear about us? (please "x" one)

- | | |
|---|---|
| <input type="checkbox"/> Phone Book | <input type="checkbox"/> Internet- Search Engine (Google, Yahoo, Bing, etc) |
| <input type="checkbox"/> Church Bulletin | <input type="checkbox"/> Internet- Facebook |
| <input type="checkbox"/> South Jersey Magazine | <input type="checkbox"/> Internet- Twitter |
| <input type="checkbox"/> SJ Magazine | <input type="checkbox"/> Internet- Instagram |
| <input type="checkbox"/> Friend/Relative: _____ | <input type="checkbox"/> Other: _____ |