



PROVIDER

APPT TIME

LOCATION

APPT DATE

THANK YOU FOR CHOOSING CAPE CORAL EYE CENTER

Date: _____

PATIENT INFORMATION

Account #: _____

Social Security #: _____

Patient Name: _____

Address: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Gender: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

| | | | |
|---------|-------------|-----------------|------------|
| Spouse: | First Name: | Middle Initial: | Last Name: |
|---------|-------------|-----------------|------------|

| | | | |
|-------------------|-------|--------|------|
| Northern Address: | City: | State: | Zip: |
|-------------------|-------|--------|------|

| | |
|----------------------|-----------------------|
| Northern Home Phone: | Email Address: |
|----------------------|-----------------------|

Race: _____ American Indian _____ Asian or Pacific Islander _____ Black _____ Caucasian
_____ Hispanic _____ Other

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

EMPLOYER INFORMATION

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone Number: _____

| | | | |
|---------------------------|-------|---------------|--------|
| Emergency Contact: | Name: | Relationship: | Phone: |
|---------------------------|-------|---------------|--------|

We'd like to know how you heard about our office (please circle one)

Building Billboard Direct Mail Insurance Internet TV
Newspaper Physician Yellow Pages Veteran's Administration Word of Mouth

Please list all the people with whom we have your permission to discuss your care. Please include your emergency contact if permission is granted.

| | |
|----|---------------|
| 1. | Relationship: |
| 2. | Relationship: |
| 3. | Relationship: |

Is it okay to leave messages about your eye health on your home answering machine? YES NO

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

Insurance Phone: _____

Subscriber/Member Name: _____

Subscriber's Date of Birth: _____ Subscriber Social Security No. _____

Policy/ID Number: _____ Group No. _____

Secondary Insurance Company: _____

Address: _____

Insurance Phone: _____

Subscriber/Member Name: _____

Subscriber's Date of Birth: _____ Subscriber Social Security No. _____

Policy/ID Number: _____ Group No. _____

Vision Insurance Company: _____

Subscriber/Member Name: _____

Subscriber's Date of Birth _____ Subscriber Social Security No. _____

Policy/ID Number: _____ Group No. _____

Please complete ONLY if patient is a minor child under the age of 18:

| | |
|----------------|----------------|
| Father's Name: | Mother's Name: |
| Employer: | Employer: |
| Work Phone: | Work Phone |

I give permission for Cape Coral Eye Center, P.A. to treat my minor child.

Child's Name: _____

Parent or Guardian Signature: _____ Date: _____

I authorize any holder of medical or other information about me, to release to the Social Security Administration, Health Care Financing Administration, it's intermediaries, carriers, any commercial insurance companies, and the billing agent of Cape Coral Eye Center, PA any information needed for this, or related Medicare and other insurance claims. I permit a copy of this authorization to be used in place of an original and request payment of Medicare insurance benefits either to myself or the party who accepts the assignment. All insurance benefits are to be made payable to the Cape Coral Eye Center. I further agree that I will be responsible for any balances and non-covered services that remain unpaid.

All of the information provided on this form is accurate and true to the best of my knowledge.

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Signature if other than beneficiary: _____ Date: _____

Reason Patient is unable to sign: _____