WELCOME TO FRANK EYE CENTER PATIENT INFORMATION 2023

Last Name_____ First Name _____ MI _____

Birth Date_____ Gender (circle) : M F Marital Status (circle) : S M D W

Address_____ City_____ State_____ Zip_____

Social Security #_____ Email*_____

Phone: HOME_____ CELL_____ WORK_____
(Circle preferred contact number)

By what name do you wish to be called? _____

Race_____ Ethnicity (circle): Hispanic/Latino Other Decline to answer

Primary Language (circle): English Spanish Other _____

Primary Care Physician_____ Address_____
Phone_____

EMERGENCY INFORMATION
Contact Name_____ DOB:_____
Relationship_____
Phone (circle) : Home Cell Work _____

PATIENT EMPLOYMENT INFORMATION
Employer_____ Occupation_____
Address_____ City_____ State_____ Zip_____

Is this a medical condition due to an accident? YES NO If yes, Date of Accident _____
How did you hear about us? Internet Friend/family Doctor Other_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

AUTHORIZATION: I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Frank Eye Center, P.A. for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider or any other party may be responsible for paying for my treatment.

*** We may use your email address to send you information about our practice. However, we will not share your email address with any other person or organization.**

I have been offered and/or received a copy of Frank Eye Center's Notice of Privacy Practice. I acknowledge that I have read and understand the office policies.
Patient Signature_____ Date_____ Or signature of parent or legal guardian if patient is under 18 years of age. Patients under 18 must have a parent/guardian present at exam OR written consent/Minor Consent Form.