# WELCOME TO FRANK EYE CENTER PATIENT INFORMATION 2025

Patient's Name _____
Last Suffix First Middle Initial Nickname

Address _____
Street Apt City State Zip Code

Date of Birth _____ Social Security Number _____ Sex: Male Female

Marital Status (circle): S M D W Email_____

Phone: Home_____ Cell_____ Work_____
(Circle preferred contact number)

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

Primary Language (circle): English Spanish Other _____

Primary Care Physician _____ Address_____

EMERGENCY INFORMATION
Contact Name_____ DOB: _____ Phone_____

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_____

**Release of Medical Information and Statement of Notice of Privacy Practices**
I hereby authorize Frank Eye Center to release my insurance or any other third-party payer any and all information necessary to process a claim on my behalf. I authorize my insurance to assign my benefits directly to Frank Eye Center. Your medical information is personal to you by law and Frank Eye Center is required to make sure it is kept private. You may obtain a copy of our privacy policy by request.

**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 that may be responsible for paying for my treatment.**

**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.**