**Carolina Eye Care, PA** **Patient Information**

Patient name _____ Patient # _____
First Middle Last

SSN _____ ___Male ___Female Birthdate _____Home Phone_____

Address _____ Cell Phone _____

City _____State ____ Zip _____ e-mail address_____

___ Minor ___ Single ___Married ___Divorced ___Widowed ___Separated

Race: _____ Ethnicity: ___ Non-Hispanic ____Other Language: ___English ___Other

Were you referred to our practice? If so, who referred you? _____

Who is your family doctor? _____

Person to contact is case of emergency _____Phone _____

## Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____

Home number _____ Cell number _____Birthdate _____

Employer _____ Work phone _____

## Insurance Information

Name of Insured _____Relationship to patient _____

Birthdate _____ SSN_____Date employed _____

Name of employer _____Work phone _____

Address of employer _____City _____State _____ Zip _____

Insurance company _____ Group # _____

Insurance address _____

Do you have additional insurance? ___ Yes ___No If yes complete the following:

Name of Insured _____ Relationship to patient _____

Birthdate _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____

Insurance address _____ City _____ State_____ Zip _____

## AUTHORIZATION

*I certify that I have read and understand the above information to best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to this party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All telephone numbers provided by me may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. I give my prior express consent to receive such phone calls, including any calls made to my provided cellular telephone number. You have the right to a paper copy of our Notice of Privacy Practices or a revised notice at any time. Please see our front desk if you would like to obtain a copy of our notice. If you have any questions about our notice or would like to exercise your privacy rights, please contact the Carolina Eye Care, PA Privacy Officer at 704-864-7789 or file a complaint in writing to the following: Office Manager, 2555 Court Drive, Suite 150, Gastonia, NC 28054.*

*X*_____

***Signature of Patient (or parent if a minor)*** ***Date***