PATIENT INFORMATION

Last Name: ______________________________

First Name: ______________________________

Middle Initial: ______________________________

Gender: Male ______________ Female ______________

Date of Birth: ______________________________

Street Address: ______________________________

City: ______________________________

State: ______________ Zip Code: ______________

Home Phone: ______________________________

Work Phone: ______________________________

Employer: ______________________________

Cell Phone: ______________________________

Your Email address: ______________________________

Social Security Number: ______________________________

Marital Status: Single Married Widowed Divorced

Primary Care Physician: ______________________________

Primary Care Physician's email: ______________________________

Referring Physician: ______________________________

Referring Physician's email: ______________________________

City: ______________ Phone: ______________

How did you learn about us? ______________________________

Preferred language: ______________________________

Race: ______________________________

Ethnicity: ______________________________

RESPONSIBLE PARTY IF NOT PATIENT

Last Name: ______________________________

First Name: ______________________________

Relationship to Patient: ______________________________

Social Security Number: ______________________________

Street Address: ______________________________

City: ______________________________

State: ______________ Zip Code: ______________

Home Phone: ______________________________

Work Phone: ______________________________

Your Email address: ______________________________

Cell Phone: ______________________________

Employer: ______________________________

Date of Birth: ______________________________

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Gossage Eye Institute's Notice of Privacy Practices.

______________ Date

____

Signature (Patient or Authorized Representative)

____

Printed Name (Patient or Authorized Representative)

EMERGENCY CONTACT INFORMATION

Emergency Contact: ______________________________ Phone (other than listed above): ______________________________

RELEASE OF INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I, the undersigned, hereby authorize the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used. The subscriber also authorizes his/her insurance company(ies) at its option to issue indemnity checks to the provider rendering service. The subscriber does hereby acknowledge knowing the provisions and coverages of his/her insurance policy(ies) and does hereby agree to pay the Gossage Eye Institute, PLC for any charges not covered by the subscriber's insurance policy(ies). **These charges shall include but are not limited to: Deductibles, copays, written prescriptions, refractions, special testing and any other non-covered charges or services provided.**

Initial current year of visit: __________2019__________2020__________2021__________2022__________2023