NASHVILLE EYE ASSOCIATES, P.C.

PLEASE PRINT

PATIENT NAME_____ **AGE**_____ **BIRTHDATE**___/____/____

ADDRESS_____ **APT#**_____ **CITY**_____ **STATE**____ **ZIP**_____

HOME PHONE (___)_____ CELL PHONE (____)_____ MALE_____ FEMALE_____

SOCIAL SECURITY#_____ ***SPOUSE OR PARENT'S NAME***_____

PLEASE CIRCLE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMERGENCY CONTACT (*not living with patient*)_____ PHONE _____ RELATIONSHIP_____

PRIMARY CARE DOCTOR_____ PHONE(___)_____

PATIENT'S EMPLOYMENT INFORMATION **IS PATIENT EMPLOYED? YES ☐ NO ☐ RETIRED ☐**

IF YES PATIENT'S EMPLOYER_____

EMPLOYER'S ADDRESS_____ CITY_____ STATE____ ZIP_____

EMPLOYER'S PHONE( )_____ OCCUPATION_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) **SELF ☐** **SPOUSE ☐** **PARENT ☐** **OTHER ☐** _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

ADDRESS_____ CITY_____ ST____ ZIP_____

EMPLOYER_____ EMPLOYER'S PHONE(___)_____

EMPLOYER'S ADDRESS_____ CITY_____ ST____ ZIP_____

INSURANCE INFORMATION **IS PATIENT UNDER HOSPICE CARE? YES ☐ NO ☐**

PRIMARY INSURANCE CO_____ **ID#**_____

Policy is in the name of_____ **Relationship to patient**_____

Insured Address (if different from patient)_____

Insured Birthdate___/___/___ **Insured SS#**_____

Insured Employer_____

SECONDARY INSURANCE CO_____ **ID#**_____

Policy is in the name of_____ **Relationship to patient**_____

Insured Address (if different from patient)_____

Insured Birthdate___/___/___ **Insured SS#**_____

Insured Employer_____

WORKER'S COMPENSATION **Is today's visit work related? YES ☐ NO ☐**

*IF **YES**, YOU **MUST** HAVE WRITTEN AUTHORIZATION FROM YOUR EMPLOYER*

NAME OF WORK CONTACT PERSON_____ **PHONE(___)**_____

ADVANCED BENEFICIARY NOTICE:

Medicare and some private insurance companies do not consider refractions (checking for glasses and contact lenses) to be a covered service. Therefore, I am responsible for payment of the refraction portion of my exam.

AUTHORIZATION AND PAYMENT TERMS:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided in order to file and evaluate claims for insurance benefit. I authorize the release of medical information to physicians and healthcare providers participating in my care. I also authorize payment of insurance benefits directly to the doctor. I understand that I have the right to a copy of the Notice of Privacy Practices in paper form.

If patient is a minor, I authorize the medical treatment and use of any diagnostic or therapeutic procedures and/or medications by the physician and his agents.

I am responsible for payment of any co-pay, deductible, co-insurance or noncovered service. I acknowledge full financial responsibility for all services provided to my minor child or me. I am responsible for payment of any collection agency fees or charges and/or attorney fees necessary to collect my account. *Payment is due on the day services are rendered, unless other approved arrangements have been made. If we are a provider, our staff will file your insurance claim.*

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (if minor) *DATE*

08/09