VISTA EYE SPECIALISTS

NEW PATIENT INFORMATON

(Please Print)

PERSONAL INFORMATION

Name _____ Date _____

Date of Birth _____Age _____☐ M / ☐ F Social Security#_____

Address_____
Street City State Zip

Phone: Home(____) _____ Cell(____) _____ Work(____) _____

Occupation _____ Employer _____

Marital Status: S / M / W / D Email : _____

Referred by (Doctor/Patient/Friend/Website/Ad):_____

SPOUSE/DEPENDENT INFORMATION (Parent/Guardian information if patient under 18 years)

Spouse/ Parent / Guardian Name _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other

Address_____
Street City State Zip

Date of Birth _____Social Security#_____

Phone: Home(____) _____ Cell(____) _____ Work(____) _____

Occupation _____ Employer _____

INSURANCE INFORMATION

☐ Medicare #_____ ☐ Medicaid # _____

Patient's Primary Insurance _____ ID #_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Date of Birth _____Subscriber's Social Security#_____

Patient's Secondary Insurance _____ ID #_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Date of Birth _____Subscriber's Social Security#_____

EMERGENCY CONTACT

Name _____ Relationship _____

Address_____
Street City State Zip

Phone: Home(____) _____ Cell(____) _____ Work(____) _____

MEDICAL AUTHORIZATION

Name of Family Member to Release Health Information_____

HIPPA DISCLOSURE & INSURANCE AUTHORIZATION / ASSIGNMENT AGREEMENT

I hereby authorize this office disclosure of health information and/or to apply for benefit on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information, to the other treating physicians and to my insurance company in order to determine insurance benefits to which I may be entitled. Either myself or my insurance company at any time may revoke this authorization in writing.

By signing below, I acknowledge that I have read and understand this authorization.

Patient/Responsible Party Signature: _____Date:_____