THE Oculoplastics CENTER

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PATIENT INFORMATION

PATIENT NAME _____
Last First MI

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____ GNC _____

SOCIAL SECURITY # (MILITARY ONLY) _____

SPOUSE'S NAME _____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY/STATE _____ ZIP _____

PHYSICAL ADDRESS _____

CITY/STATE _____ ZIP _____

MAILING AND PHYSICAL ADDRESS THE SAME □

BEST CONTACT NUMBER _____ WORK NUMBER _____

EMAIL _____

REFERRED BY **PRIMARY CARE PHYSICIAN**

BILLING: Please complete the information below if the person responsible for the bill is **not the patient listed above**.

NAME _____
Last First MI

DATE OF BIRTH _____ SOCIAL SECURITY # (OPTIONAL) _____

RELATIONSHIP TO PATIENT _____ OCCUPATION _____

ADDRESS _____

CITY/STATE _____ ZIP _____

BEST CONTACT NUMBER _____ WORK NUMBER _____

Please name here any person you authorize our office to speak to regarding you protected health information:

EMERGENCY INFORMATION: Person to contact in case of emergency.

NAME: **PHONE:** **RELATIONSHIP:**

Please read the following statements carefully before signing.

1. I authorize treatment of the person named above and agree to pay all fees for such treatment.
2. I hereby authorize The Oculoplastics Center to receive all benefits to which my dependents or I are entitled to under my health insurance plan(s).
3. I authorize The Oculoplastics Center, and their agents, to release any medical information acquired in the course of my examination or treatment to process my insurance claims.
4. I have read and agree to the terms listed on "Notice of Privacy Policies for The Oculplastics Center."

SIGNATURE_____ RELATIONSHIP TO PATIENT_____

DATE_____