

PATIENT INFORMATION

Name _____ Spouse _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

Sex Female Male Date of Birth ____ / ____ / ____ SSN _____ - ____ - ____

E-mail Address _____

Race Black or African American White Asian American Indian or Alaskan Native Native Hawaiian or other Pacific Islander Other

Ethnicity Hispanic or Latino Not Hispanic or Latino

Patient's Employer _____ Occupation _____

If patient is a minor, list parent/guardian names _____

Person (not living with you) to notify in emergency _____ Phone _____

Do you have a living will or written Durable Power of Attorney? Yes No

By my signature below, I acknowledge that I have received the Privacy Notice of Montgomery Eye Physicians. I understand that the physicians and employees of Montgomery Eye Physicians WILL NOT discuss my health information with my family or friends unless I expressly authorize them to do so. I may revoke this authorization at any time in writing. I hereby authorize the physicians and employees of Montgomery Eye Physicians to convey information about my health to the following people:

_____ Phone _____ Relationship _____

_____ Phone _____ Relationship _____

Unless you direct us not to, Montgomery Eye Physicians will call your home telephone regarding appointments or other aspects of your care. If you have caller ID, any calls from our office will register.

Please check one:

- You may call my home and if necessary, leave a message.
- You may call my home but DO NOT leave a message if you do not reach me directly.
- DO NOT call my home for any reason.

Signature _____ Date _____

Primary Insurance Company _____

Subscriber's Name _____ Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company _____

Subscriber's Name _____ Date of Birth _____ Relationship to Patient _____

I hereby authorize payment of medical insurance benefits be made directly to Montgomery Eye Physicians, P.C. I understand that I am fully responsible for all charges that are not covered by this assignment. In case of default of payment, this will be placed in the hands of any agency for collection and all attorney fees, costs and all other expenses will be paid by the undersigned. I also authorize the release of any medical information necessary to process all claims.

Signature of Responsible Party _____ Date _____