WELCOME TO MID AMERICA EYE CENTER

PATIENT INFORMATION

Last name _____ First name_____ Middle Initial _____

Birth date_____ Marital Status: □Single □Married □Divorced □Widowed

Sex: □ M □ F Gender Identity: □ Male □ Female □ Female-to-male □ Male-to-female □ Non-binary

Address_____ City_____ State_____ Zip_____

Social Security #_____ Email_____

Phone: □ Home_____ □ Cell_____ □ Work_____

Check preferred contact number

Race_____ Ethnicity: □ Hispanic/Latino □ Other_____ □ Decline to answer

Primary language: □ English □ Spanish □ Other_____ Translator? □ Y □ N

Primary Care Physician_____ Address_____ Phone_____

Preferred Pharmacy_____ Address_____

EMERGENCY INFORMATION

Contact name_____ Relationship_____

Phone: □ Home □ Cell □ Work _____

PATIENT EMPLOYMENT INFORMATION

Employer_____ Occupation_____

Address_____ City_____ State_____ Zip_____

How did you hear about us? □ Internet □ Friend/family □ Doctor_____
□ Other _____

With whom may we speak about financial statements, test results, or other services provided by our office regarding your medical treatment? *(list all that apply)*

Name(s)/relationship_____ □ No one

PLEASE SEE OTHER SIDE

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

AUTHORIZATION: I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Mid America Eye Center for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider or any other party that may be responsible for paying for my treatment.

We may use your email address to send you appointment reminders or information about our practice and specials. However, we will not share your email address with any other person or organization.

□ I acknowledge receipt of notice of privacy practices.

□ I authorize Mid America Eye Center to view my prescriptions from external sources.

□ I acknowledge that I have read and understand the office policies, including insurance information.

Patient Signature_____ Date:_____

*Or signature of parent or legal guardian if patient is under 18 years of age. *Signature valid for one year*

Patients under 18 must have a parent/guardian present at exam OR written consent/Minor Consent Form.