MARTINSVILLE EYECARE CENTER

PATIENT INFORMATION

NAME (LAST)	SUFFIX	FIRST	M.I.

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE #	CELL # or ALTERNATE #	SEX **M F**	DATE OF BIRTH	SOCIAL SECURITY #

EMAIL ADDRESS	COMMUNICATION PREFERENCE (circle) PHONE E-MAIL TEXT MAIL	RACE

PATIENT'S EMPLOYER	ADDRESS	WORK #

MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY #

PRIMARY CARE PHYSICIAN OR MEDICAL DOCTOR	ADDRESS & PHONE # OF DOCTOR

NAME OF PHARMACY YOU ARE CURRENTLY USING	PHARMACY LOCATION OR ADDRESS

NAME OF OPTOMETRIST OR LAST EYE DOCTOR YOU SAW	ADDRESS & PHONE # OF DOCTOR

RESPONSIBLE PARTY INFORMATION (complete ONLY if different from above information.) Must be completed if patient is under 18 years old.

NAME (LAST)	FIRST	M.I.

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE #	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

INSURANCE INFORMATION (Please bring insurance cards to appointment)

VISION INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER & ADDRESS

PRIMARY MEDICAL INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER

SECONDARY MEDICAL INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER

How did you learn about our office? (Please check one)

_____ Friend/Family (Who)_____ _____ Medical Doctor _____ Other

_____ Previous Patient (Who)_____ _____ Yellow Pages

"I, the undersigned , certify and assign to Dr. Theresa Bechtel all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods.

SIGNATURE_____ DATE_____

NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have been informed of / offered this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPPA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. You are free to refer to this policy at any time. These policies are subject to change or be modified as legislation changes.

I give permission to Martinsville Eyecare Center to discuss or release health information identifying me to my insurance companies, referrring/consulting physicians and the following people and entities:_____

Signature_____ Date_____