EYES, P.A.

UPDATED PATIENT INFORMATION

Name: _____ Date: _____

Birthdate: _____ Marital Status: Married Single Widowed Other: _____

Race: Native American African American White Other: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: Home:_____ Cell:_____ Work:_____

Email Address: _____

Parent or Guardian's Name If Patient Under 18: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship: ☐ SPOUSE ☐ PARENT ☐ FRIEND ☐CHILD ☐ SIBLING ☐ OTHER _____

☐ **Check here to give Eyes, P.A. Staff permission to speak with your alternate contact regarding your health issues**

Who referred you or how did you hear about us? _____

How do you plan to pay of your examination? ☐ **Self-Pay** ☐ **Medical Insurance**

What pharmacy do you use?_____ In what town?_____

Current Occupation/Employer: _____

I hereby give my consent to receive treatment from EYES, P.A., Dr. Jessica Barbay, Dr. Mary Markovic, and/or Dr. Paul Mormon. I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case. This notice is effective as of (Date). This authorization will expire seven years after the date in which you last received services from us. I authorize you to use or disclose my health information in the manner described above. By signing below I also acknowledge that I have had the opportunity to review my patient rights and know I can request a copy of them at any time.

Print Name _____

Signature: _____ Date: _____

All professional services rendered are charged to the patient. Requests for payment from your insurance company will be submitted; however, you are responsible for all fees, regardless of insurance coverage. Should your account be delinquent, a collection charge maybe added to the outstanding balance. We ask for payment of services when rendered unless other arrangements have been made in advance.

I hereby assign Eyes, P.A., Dr. Jessica Barbay, Dr. Mary Markovic and/or Dr. Paul all payments for vision and medical services rendered to me or my dependents. I understand that I am responsible for any balance not covered by my insurance.

Signature: _____ Date: _____