



The Eye Care Institute

Patient Data Form

Name: _____
Last First Middle

Address: _____
Street City/State Zip Code

County Of Residence: _____

E-Mail: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Gender: Male Female Marital Status: Sgl Married Divorced Widowed

Occupation: _____ Business Phone: _____

Employer: _____

Employer Address: _____

Nearest Relative/
Friend Not Living
With You: _____
Name Telephone Number Relationship

Who Referred You
To Our Office: _____

Your Family
Doctor/Internist: _____
Practice/Name Telephone Number

Work Related
Injury: Yes No

If so, please complete the following:

Name of
Responsible
Party: _____

Address: _____
Street City/State Zip Code

Telephone: _____

Type of
Insurance: _____

If you have your insurance cards with you, please give them to us so we can make a copy for our records.

Subscriber: _____ D.O.B.: _____

Employer: _____ Telephone Number: _____

(CONTINUED ON REVERSE)

Assignment and Release:

The Eye Care Institute has advised me that my eyes may be dilated for each exam. I further understand that I have been advised to provide myself transportation and it is not recommended that I drive after being dilated. I accept all responsibility for the consequences of not following these recommended guidelines. Further, I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all co-insurances, deductibles and non-covered services. I am responsible for obtaining all referrals or pre-authorizations required by my insurance carrier. I authorize release of information to process insurance. The medical history and information I have provided is complete and accurately represents my medical condition. I authorize any employee of The Eye Care Institute to access my medical and financial records for any medical, billing or administrative purpose.

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____