TRISTATE CENTERS FOR SIGHT

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security: _____

_____ Sex: _____

City: _____ Language: _____ Race: _____

State: _____ Zip: _____ Ethnicity: _____

Marital Status: S M W D Employer: _____

Spouse Name: _____ Employment Status: Full-time Part-time Retired NA

Home Phone: _____ Student Status: Full-time Part-time NA

Work Phone: _____ Emergency Cont: _____

Cell Phone: _____ Emergency Phone: _____

Pharmacy: _____ Pharm. Location: _____

Pharmacy Phone: _____ Pts. email: _____

GUARANTOR INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security: _____

_____ Employer: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Patient Relationship Guarantor: _____

INSURANCE INFORMATION

Primary Ins: _____ **Secondary Ins:** _____

Certificate #: _____ Certificate # _____

Group Number: _____ Group Number: _____

Group Name: _____ Group Name: _____

Copay: _____ Copay: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

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PAGE TWO

Patient Name_____

Tertiary Ins:_____ **Workers' Comp:**_____

Certificate #:_____ Employer @ Time of Injury_____

_____

Group Number:_____ Contact Person:_____

Group Name:_____ Phone Number_____

Copay: _____ Date of Injury:_____

Subscriber Name:_____ Carrier:_____

Subscriber DOB: _____ Claim Number: _____

ADDITIONAL INFORMATION

Patient AKA (Alias) Name: _____

Preferred Contact Number: _____

Primary Care Physician: _____

Referring Physician: _____

How did you hear of our Practice:

Cyclones	Employee	ER
Friend	Insurance Company	Internet
KY Screening	LASIK Mailing	Newspaper
Nursing Home	Optometrist	Physician
Previous Patient	Project Access	Radio
Reds	Relative	School
Signage	Skin Care Event	SS Administration
TV	Veterans Administration	Yellow Pages

Authorization to Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, TriState Centers For Sight when they accept assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, TriState Centers For Sight to release any information necessary for my course of treatment.

_____ _____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

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