NORTH IOWA EYE CLINIC, P.C. Patient Information Form

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Patient Information

Patient's Name:_____ Sex_____M_____F
First Middle Initial Last

Address: _____
Street Apt # City State Zip

Telephone: (Home) _____ (Cell)_____

Your Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth : _____/_____/_____

Current marital status: ____ Single _____ Married Student _____Y_____N

Employer: _____ Phone_____

Emergency Contact (someone who does not live with you)_____ Phone #_____

Spouse or Parent Information (<u>list the parent that carries the insurance</u>)

Name:_____ Relationship to Patient:_____

Address: _____
Street Apt # City State Zip

Social Security Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Date of Birth: _____/_____/_____

Employer: _____ Phone_____

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Referral Information

Doctor who referred you:_____ Family Doctor_____

Insurance Information

<u>Please bring insurance cards and present at check-in.</u>

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Medicare and Private Insurance Authorization for Assignment of Benefits and Information Release

I hereby authorize examination and other medical services deemed necessary by North Iowa Eye Clinic, P.C. I, the undersigned, authorize payment of medical benefits to North Iowa Eye Clinic, P.C. for any services furnished to me by the physicians. I understand I am financially responsible for any amount not covered by my contract. I also authorize the North Iowa Eye Clinic, P.C. to release to my insurance company information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims or benefits.

I request that payment of authorized medical benefits be made either to me or on my behalf to the North Iowa Eye Clinic, P.C. for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits payable for related services. I understand this is lifetime authorization.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented at the time of my visit with a copy of the Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____ Date:_____

Relationship (if not signed by patient)_____