Patient Information

Date_______________

Last Name:_____________________ First Name: ______________ Middle Initial: _______ Nickname: ______________

Address:____City:______________State:_________Zip______________

Phone (______)_________________ Work Phone (_____) _______________ Cell Phone (______)____________________

The best time to contact me is:_________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_______________ Age: _____ Sex ☐ Male ☐ Female Social Security Number:_________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Were you referred by a physician? ☐ Y ☐ N If Yes, Name______________________________

Primary Care Physician_______________________________ Address: _______________________________________

Spouse or Parent's Name:______________________________ Employer__________________ Work Phone____________

How did you hear about us: ☐ Friend ☐ Relative ☐ Newspaper ☐ Internet ☐ Mailing ☐ Phone Book

Person to contact in case of emergency____________________________________ Phone_________________________

Email Address____ Language ☐ English ☐ Spanish ☐ Chinese ☐ Other __________

The State of Tennessee and the Department of Health requires us to ask you the following questions:

UDS Race: ☐ White/Caucasian ☐ Black/African American ☐ Native American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Other Race (other than 1-4) ☐ Unknown Race
UDS Language Barrier: ☐ None ☐ Yes – Other than English ☐ Yes – Sign Language
UDS Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Hispanic Origin Unknown

Responsible Party

☐ Check if same as above, if not, please complete below

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Name:____ Relationship to Patient: ______________________

Address:____City:_________________________________ State:_________

Zip:_____________ Phone: (____)_____________________

Employer_________________________ Work Phone (____)_________________ SSN#______________________________

PLEASE COMPLETE REVERSE SIDE

Insurance Information

Name of Insured_________________________DOB___________Relationship to Patient ____________
SSN#:______________ Name of Employer:_________________ Work Phone: (___)___________
Address of Employer:___________________________City_____________State:______Zip _________
Insurance Company______________________ Group #_________________ ID#___________________
Ins Co Address:____________________________________ Ins Co. Phone:______________________
------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING -----------

Name of Insured_________________________DOB___________Relationship to Patient ____________

SSN#:______________ Name of Employer:_________________ Work Phone: (___)___________

Address of Employer:___________________________City_____________State:______Zip _________
Insurance Company______________________ Group #_________________ ID#___________________
Ins Co Address:____________________________________ Ins Co. Phone:______________________

If patient is a minor, please provide the following information:

Father's Name_________________________ DOB___________ Home Phone ____________
Home Address ________________ City ________________ ST _____ Zip ____________
Name of Employer:_________________ Work Phone: (___)___________

Mother's Name_________________________ DOB___________ Home Phone ____________
Home Address ________________ City ________________ ST _____ Zip ____________
Name of Employer:_________________ Work Phone: (___)___________

If office visit is due to an accident, please provide the following information:

Date of Injury ____________ Is Injury work related ? ☐ Yes ☐ No If yes, give supervisor's name __________________
Supervisor Phone Number: _________________________

Work Comp/Voc Rehab: ____

Patient Information Release Authorization and Assignment of Insurance Benefits

I hereby authorize The Reeves Eye Institute to obtain from and to release to my healthcare team and my insurance company(s) any information required for the purposes of healthcare management and for processing medical claims on my behalf. I authorize my insurance company to pay benefits directly to The Reeves Eye institute.

Signature: ____ Date: __________________

Responsibility for Payment

I understand that it is my responsibility to notify The Reeves Eye Institute of any changes in or special requirements of my insurance coverage. I accept responsibility for all fees not paid by my insurance related to my care. This includes, but is not limited to deductibles, co-insurance, and non-covered services. The Reeves Institute will bill me directly for any amounts not paid by my insurance. I agree to pay any balance due.

Signature: ____ Date: __________________