Hodges Eye Care and Surgical Center

The view from here is always clear.

PATIENT INFORMATION

(Office Use)

Account #_____

Welcome To Our Office

Last Name	First Name	M.I.	Social Security #	Date of Birth	
Street Address		City	State	Zip Code	Home Phone
Marital Status: (Circle One) S M D W	Sex: (Circle One) Male Female	Who Referred you to our office or how did you hear about us?			
Employer		Occupation		E-Mail Address	
Employer's Street Address		City	State	Zip Code	Business Phone
Spouse or Parent's Name		Address (If different from above)			
Spouse of Parent's Employer		Occupation			
Employer's Street Address		City	State	Zip Code	Business Phone
Primary Care Physician's Name		Address			Office Phone

It is customary to pay for services when rendered unless arrangements have been made in advance with our office manager. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

Responsible Party	Relationship	Social Security #	Date of Birth
Address (if different from above)	City	State	Zip Code
Primary Insurance Company	ID #	Group #	Subscriber Name
Insurance Address	City	State	Zip Code
Secondary Insurance Company	ID #	Group #	Subscriber Name
Insurance Address	City	State	Zip Code
In case of emergency, please notify (someone not living with you):			Phone:

Authorization to Release Information I hereby authorize the release of any medical or other information acquired in the course of examination or treatment to my insurance company to process my claim or to another doctor who may be treating me.

Signature_____ Date_____

Are you interested in Refractive Surgery? ____Lasik ____CK ____ReStor