CAROLINAS CENTERS FOR SIGHT, P.C.

PATIENT INFORMATION

PATIENT NAME: _____ S.S.#: _____

STREET ADDRESS: _____ P.O. BOX: _____

CITY/STATE/ZIP: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMPLOYER: _____ WORKERS COMP? Y_____ N_____

BIRTHDATE: _____ AGE: _____ RACE: _____ MARITAL STATUS: _____ SEX: _____

SPOUSE NAME: _____ SS#: _____ DOB: _____

GUARDIAN NAME (if under 18) _____ SS# _____ DOB: _____

GUARDIAN EMPLOYER: _____ WORK PHONE #: _____

EMERGENCY CONTACT NAME & PHONE # AND OR PERSON AUTHORIZED TO RELEASE INFORMATION TO: _____

_____

_____

INSURANCE INFORMATION

Primary Insurance Co. _____ Secondary Insurance Co. _____

PLEASE GIVE YOUR INSURANCE CARDS AND PICTURE I.D.TO THE RECEPTIONIST TO MAKE A COPY. WE REQUIRE A PICTURE I.D. TO FILE YOUR INSURANCE.

Claims will be filed for payment to those insurance plans with which Carolinas Centers for Sight, P.C. is a contracted Participating Provider. Co-Insurance amounts, Non-Covered amounts, and Deductible amounts will be collected at the time of service.

I hereby request evaluation and treatment necessary by Carolinas Centers for Sight, P.C. I hereby authorize payment of insurance benefits directly to Carolinas Centers for Sight, P.C. for services rendered, including applicable Medi-Gap policies. I further authorize the use of my health information for the purpose of treatment, payment or healthcare operations. I understand that I am responsible for payment of any amount not covered by insurance.

Signature Required_____ Date: _____

HOW WERE YOU REFERRED TO US?

___ Doctor _____ ____ SHE Magazine ___ Insurance ____ Website / Internet ____ The Link

___ Other: _____ ____ Family/Friend ___ Staff ____ Morning News ____ T.V.

___ The Item ____ Expo/Show ____ Radio ____ Golden Life ___ Chamber Directory __ Yellow Pages