



New Patient Information Form

Chart #

Name: First			Middle			Last			Today's Date:		
Drivers License # / State						Patient Social Security #					
Home Phone:						Patient Birth Date:			Age:		
Work Phone:						Circle one: MALE FEMALE					
Cell/Other Phone:						Employer/Occupation					
Local Mailing Address:					Apt/Lot#		Emergency Contact:				
City:			State:		Zip:			Phone:			
Out of Town / Other Address:					Apt/Lot#		Relationship to Patient:				
City:			State:		Zip:			Spouse Name:			
PRIMARY Insurance Company:											
Policy Holder's Name:						Policy Holder's Date of Birth:					
ID/Policy#:				Group#:				Policy Holder's Social Security #:			
Relationship of patient to Policy Holder:						Policy Holder's Employer/Phone:					
SECONDARY Insurance Company:											
Policy Holder's Name:						Policy Holder's Date of Birth:					
ID/Policy#:				Group#:				Policy Holder's Social Security #:			
Relationship of patient to Policy Holder:						Policy Holder's Employer/Phone:					
Do you have an Optometrist? Yes No						E-mail Address					
Dr. _____						May we e-mail you? (circle one)					
Date of last examination: _____						YES			NO		



AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize the release of my medical information to my insurance company and the assignment of benefits from my insurance company to Manatee Sarasota Eye Clinic.

Patient/Parent/Guardian Signature: _____

Date: _____

PATIENT RESPONSIBILITY FOR PAYMENTS: In being accepted as a patient of Manatee Sarasota Eye Clinic, I realize I am responsible for all charges incurred. Payment is due at time of services are rendered (unless prior arrangements are made in writing). I understand that Manatee Sarasota Eye Clinic will file my insurance for me, but I am responsible for deductibles, co-payments, uncovered services, refractions, and claims denied by my insurance company.

Patient/Parent/Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Manatee Sarasota Eye Clinic has the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office or by visiting their web site at www.youreyedoctors.com.

Patient/Parent/Guardian Signature: _____

Date: _____