



SHEPHERD EYE CENTER PATIENT INFORMATION FORM

PATIENT INFORMATION

DATE: _____

NAME: _____ PRIMARY DOCTOR: _____

SOCIAL SECURITY NUMBER: _____ SEX (CHECK ONE): M F

DATE OF BIRTH: _____ MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

SPOUSES NAME: _____ SPOUSE'S DATE OF BIRTH _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME: _____

SOCIAL SECURITY NUMBER: _____ SEX (CIRCLE ONE): M F

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ HOME PHONE: _____ CELL: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ POLICY # _____

NAME OF INSURED: _____ DATE OF BIRTH OF INSURED _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ POLICY # _____

NAME OF INSURED: _____ DATE OF BIRTH OF INSURED _____

RELATIONSHIP TO PATIENT: _____

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY POLICIES

My signature below acknowledges the receipt of Shepherd Eye Center's *Notice of Privacy Policies*.

Signature

Date

Print Name

Social Security #



PATIENT CONTACT

Shepherd Eye Center may contact you regarding appointments, test results, financial matters/billing concerns by telephone at any number associated with your account and leave a message as necessary. This can include wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, if an email is provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing system if applicable.

My **PREFERRED METHOD OF CONTACT** is:

Telephone number _____ Cell number _____

Email _____ Other _____

RELEASE OF PHI TO SPECIFIED PARTIES

Do we have permission to release your protected health information to anyone involved in your care? YES NO

If "YES", list the **name(s)** of the person(s) who has permission for access to your protected health information. Please do not use general descriptions such as "**family**", or "**friend**". We need name, relationship and phone number. Also, list information they have access to, for example, "entire medical records", "specific dates", "specific types of examination", etc.

Name _____
Relationship _____
Information _____
Telephone _____

Name _____
Relationship _____
Information _____
Telephone _____

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely, unless revoked in writing.

Patient Name Patient/Parent/Guardian Signature Date

Patient representative signature if patient unable to sign. _____
Relationship _____ Date _____

GUARDIANSHIP AND/OR HOSPICE CARE INFORMATION

Does someone have Power of Attorney or legal guardianship for you? Yes No

Are you currently under in-patient or out-patient hospice care? Yes No

If you answered yes, to either of these questions, please provide us with contact information for the guardian and/or the hospice. Shepherd Eye Center also needs a copy of the POA or legal guardianship paperwork if this applies.

Legal Guardian Name _____ Phone _____

Name of Hospice Service Case Manager's Name Telephone Number

