Patient Information

east memphis optometry

Date________________________

Name____Social Security #___________________________

Address____

City_____________________________State_______________________Zip________________________

Home Phone___________________ Cell Phone____________________

E-Mail____ Preferred method to contact: ❑ Home ❑ Cell ❑ Work

❑ Tæ|^ÁÁÁ❑ÁØ^{æ|^ÁÁÁÁÓã¦c@åæc^´´´´´´´´´´´´´´´´´´´´´ÁÁŒ*^´´´´´´ ÁÁÒc@}ã&ãc^KÁ❑ÁÁÞ[}ÁPã•]æ}ã&Á[¦ÁŠæcã}[ÁÁ❑ÁÁPã•]æ}ã&Á[¦ÁŠæcã}[Á

Race: ❑Á Œ{^¦ã&æ}ÁQ}åãæ}ĐŒ|æ•\æÁÞæcãç^ÁÁÁ❑ÁÁÁŒ•ãæ}ÁÁÁÁ❑ÁÁÁÁÓ|æ&\Á[¦ÁŒ~¦ã&æ}ÁĐŒ{^¦ã&æ}

❑ Pæ¸æããæ}ĐÚæ&ã~ã&ÁQ•|æ}å^¦ i Y@ãc^Á Á i Uc@^¦Á´´´´´´´´´´´´Á

Patient Employed by_______________________________ Occupation_____________________________

Business Address_____________________________ Business Phone_______________________________

Whom may we thank for referring you? ____

What is your reason for visit? ____

Emergency Contact

Name____Relationship___________________________

Home Phone_______________________ Cell Phone_________________________

May we disclose pertinent medical information about you to this emergency contact person? ___YES ___NO

Please list any other individuals you permit us to discuss your protected health information with.

____

Insurance Information

___ I will be paying for today's visit myself. ___ Today's visit will be a worker's comp claim.

Primary Insurance Company____ ___ I am the policy holder

Policy Holder's Full Name ____

Social Security # _______________________________ Relationship to Patient___________________________

Policy Holder's Date of Birth___________________ Employer____________________________________

Secondary Insurance Company____ ___ ÁI am the policy holder

Policy Holder's Full Name ____

Social Security # _______________________________ Relationship to Patient___________________________

Policy Holder's Date of Birth___________________ Employer____________________________________

Please read and initial by each statement, indicating your agreement.

____ By signing below, you acknowledge that you received/reviewed a copy of the HIPPA Notice of Privacy Practices for John T. Lee O.D., P.A. (East Memphis Optometry) (available at the front desk.) The Notice explains how your medical information can be used and disclosed and how you can access that information. We encourage you to read it. If you have any questions, please ask.

____ All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is solely responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I have presented myself for treatment to the physicians of John T. Lee O.D., P.A. (East Memphis Optometry) and hereby authorize these physicians to perform the necessary examinations and procedures that are medically necessary for my treatment. I understand that these services may or may not be covered by my insurance plan, and I will be responsible for payment of any charges my insurance plan does not cover.

____ I have authorized the release of any information acquired in the course of my examination or treatment and authorize payment directly to the physician. I also permit a copy of this authorization to be used in place of the original.

Signature:____ Date:________________________________