COMMUNITY
EYE CARE
SPECIALISTS

COMMUNITY
SURGERY&LASER
CENTER

Patient Demographic Information

Date____/____/____

Last Name _____ First Name_____ M____
Address_____
City_____ State_____ Zip_____ Birth Date ___/___/____
Social Security_____ Marital Status_____ Gender: ☐Male ☐ Female
Home Phone (_____)_____ Cell (_____)_____
E-mail_____ Preferred Language_____
Preferred contact method: ☐Phone ☐Text ☐E-mail
Preferred contact number: ☐Home ☐Cell
I give permission for messages to be left on my answering machine: ☐Yes ☐No
Are you under Hospice Care? ☐Yes ☐No
Are you a diabetic? ☐Yes ☐No

☐I authorize Community Eye Care Specialists to email or text me regarding appointment reminders.
☐I do not want to receive appointment reminders via email or text message and revoke any previous authorization to do so. **I understand I will receive reminders by phone call only.**

I have read and agree to Community Eye Care Specialists' Communication Agreement:_____
(Initials)

Family Doctor_____ Referring Physician_____
Employer_____ Occupation _____
Disabled ☐Yes ☐ No If yes, explain: _____
Race_____ Ethnicity_____ Religion_____
Interest(s)_____

Emergency Contact (nearest relative or friend):
Name_____ Relationship_____ Phone (____)_____
Address_____

If under 18, please provide the following guarantor information:
Name of Parent / Guardian_____ Relationship_____
Phone (_____)_____ Social Security_____ Date of Birth____/____/____
Address (if different from above)_____
_____

Continue on next page →

Patient Demographic Information Cont.

Last Name_____ First Name_____ MI_____

Permission to Release Information

I authorize the physicians and staff of Community Eye Care Specialists to release my medical information as follows. I understand that this remains effective until such time that I inform the practice and complete another written form.

I authorize the release of (Check all that apply): ☐ Appointment Time ☐ Insurance/Billing Information ☐ Test, Lab, and Biopsy Results ☐ Plan of Treatment ☐ Medications

To the following person(s) (check all that apply):

Parent ☐ Yes ☐ No If yes, name: _____

Spouse ☐ Yes ☐ No If yes, name: _____

Adult Children ☐ Yes ☐ No If yes, name(s): _____

Other ☐ Yes ☐ No If yes, name(s) / relationship: _____

I have read and understand *Community Eye Care Specialists'* Notice of Privacy Practices: _____ (Initials)

I have read and agree to *Community Eye* Care *Specialists'* Financial Agreement: _____ (Initials)

It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance. I request that payment of authorized insurance benefits be made on my behalf for any services furnished to me. I authorize any medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier I have, including any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by said insurance. This agreement will remain in effect until revoked by me in writing.

I have read and understand the above financial statement: _____
(Patient or Parent/Guardian Signature)

For Internal Use Only:

All information is updated in the practice management: ☐

Witness Initials: _____