NEW / UPDATED PATIENT INFORMATION

(Please Print)

Patient Name _____ Date _____

Patient Address _____City _____State _____Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security Number _____ Email_____

Sex _____M _____ F Age _____ Birthdate _____ Marital Status _____

Spouses Name _____ Spouses Employer _____

Emergency Contact Person _____ Phone Number (_____) _____

Nearest Relative _____Phone Number (_____) _____

(Not Living With You)

Patient Employed By _____ Business Address_____

Family Physician _____ Practice Location _____ (City)

Hospital Affiliation of Your Family Physician _____

Referring Doctor_____

How Did You Learn of Our Practice? _____

Purpose of Visit _____

Who Is Responsible For This Account? _____

AUTHORIZATION OF PAYMENT BENEFITS TO PHYSICIAN

I, the undersigned give my authorization to treat and assign directly to Zen Eye Institute, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Patient or Responsible Party Signature _____ Date _____