Cookeville Eye Specialists & Laser Center

PATIENT INFORMATION

_____
First Middle Last, Suffix

Address: _____

_____ _____ _____
City State ZIP

SSN: _____ Circle: Single/Married/Other

DOB: _____ Circle: Male/Female

Check the boxes for your preferred contact means:

☐ Mobile Phone: _____

☐ Home Phone: _____

☐ Email: _____

Preferred Contact: _____

Emergency Contact: _____
First Last

Relationship: _____

Phone: _____

☐ Mobile ☐ Home ☐ Work

Circle: Employed | Student

Occupation: _____

Company or School: _____

Address: _____

_____ _____ _____
City State Zip

Race: ☐ Asian ☐ African American ☐ Hispanic/Latino
☐ Caucasian ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ ASL
☐ Other: _____

Primary Care Physician: _____

Referral Source: _____

Referred by Patient: ☐ Yes ☐ No

POLICY HOLDER INFORMATION

Employer: _____

_____
First Middle Last

Address: _____

_____

_____ _____ _____
City State Zip

DOB: _____

SSN: _____

Phone: _____

Patient Relationship to the Policy Holder:

_____

INSURANCE INFORMATION

*****PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST*****

Do you have medical insurance? ☐ Yes ☐ No

Insurance: _____ **Effective Date:** _____

Policy No.: _____

Insurance: _____ **Effective Date:** _____

Policy No.: _____

AUTHORIZATIONS

- I hereby authorize and request the medical treatment necessary for the care of the above patient.
- I authorize COOKEVILLE EYE SPECIALISTS to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.
- I acknowledge full financial responsibility for services rendered at COOKEVILLE EYE SPECIALISTS. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.
- I further authorize and request that insurance payments be made directly to COOKEVILLE EYE SPECIALISTS if they elect such an arrangement.
- I acknowledge that I have received a copy of the Notice of Privacy Practices. A copy is in the front of the office.
- I acknowledge my email may be used solely to relay information regarding appointments, non-critical test results, or other general information.
- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.

☐ I have read and fully understand the above consent for treatment, for the release of protected health information, for financial responsibility, and for insurance authorization.

_____ _____

Patient / Parent or Guardian Signature Date