PATIENT DEMOGRAPHIC FORM

NEW: _____ **RETURNING:** _____ **DATE:** _____

PATIENT INFORMATION: (PLEASE PRINT)

First Name | Middle Name | Last Name | Date of Birth

Street Address | City/State | Zip Code

Home Phone (with area code) | Cell Phone (with area code)

Email Address | Work Phone (with area code)

Occupation/Employer

RETIRED: _____ **DISABLED:** _____ _____ _____ _____ S M D W

Social Security Number | Martial Status

WHO REFERRED YOU TO THIS OFFICE? (Please give the full name of the physician and phone number with area code.**)**

PRIMARY CARE PHYSICIAN/PEDIATRICIAN (Please give the full name of the physician and phone number with area code.**)**

FINANCIAL RESPONSIBILITY (If the patient is NOT responsible for payment of services rendered, please complete below.**)**

Spouse/Parent | Relationship to Patient

Street Address | City/State/Zip Code | Home Phone (with area code) | Cell Phone (with area code)

Date of Birth | Social Security Number | Employer | Work Phone (with area code)

INSURANCE INFORMATION:

PRIMARY: _____ SECONDARY: _____

Name of Insurance Company | Name of Insurance Company

VISION INSURANCE: _____ WORKER'S COMP: _____

Name of Insurance Company | Name of Insurance Company

IN CASE OF EMERGENCY, NOTIFY:

Name | Phone Number (with area code) | Relationship to Patient

UAB CALLAHAN EYE

NAME OF PERSON(S) WHO WE MAY SPEAK WITH ABOUT YOUR MEDICAL CARE:

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

DO YOU WEAR CONTACTS OR GLASSES? _____ **HOW LONG?** _____

LIST ANY ALLERGIES TO MEDICATIONS _____

NAME OF PHARMACY _____

PHARMACY ADDRESS _____

TO OUR PATIENTS:

Payment is due from the patient at the time services are rendered. Callahan Eye Hospital & Clinics (CEH&C) accepts assignment on Medicare and certain other insurance companies with which we have contractual agreements. Patients are responsible for any applicable co-payments, deductions, refractions, and any other services not covered by their insurance programs.

Refraction, which is part of our complete eye examination, may NOT be covered under most insurance programs. PATIENTS ARE RESPONSIBLE FOR REFRACTIONS.

Routine eye examinations are NOT covered services under some programs. These programs may cover an eye examination only if it is related to an illness or injury.

Most Health Maintenance Organizations require a referral from one of their physicians before services may be performed. If your carrier requires a referral, you will be responsible for all services performed without a referral. I have read and understand the policy regarding referrals and agree to pay for any services that are rendered for which I have not secured a referral as required by my contract.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

CEH&C and attending physicians are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT AUTHORIZATION:

If assignment applies to any of the charges incurred, I hereby authorize the insurance company to make payment directly to CEH&C and its physicians.

STATEMENT OF RESPONSIBILITY:

The information is given for the purpose of obtaining treatment with CEH&C and attending physicians. I understand that payment is expected at the time of each visit and that I am responsible for all charges incurred on this account. In the event that charges become delinquent, I agree to pay all the cost of collection, including reasonable attorney's fees.

I HAVE READ, UNDERSTAND, AND AGREE to the payment policies of this office. All of the information I have provided is complete and correct to the best of my knowledge.

_____

PATIENT SIGNATURE **DATE**

UAB CALLAHAN EYE