PATIENT INFORMATION

Patient Full Name _____

Address _____

City _____ _____ St _____ Zip _____

Home Phone # (____)____-_____ Mobile Phone # (____)____-_____

SS# ____-___-_____ DOB ___/___/_____ Age____ □ Female □ Male

Employed: □ Full-time □ Part-time □ Retired □ Disabled □ Student

Occupation: _____

Medical Insurance: _____ ID # _____

Whose name is insurance in? □ Self □ Spouse □ Parent/Guardian

If not self: Name of insured_____

Vision Insurance: _____ ID # _____

Whose name is insurance in? □ Self □ Spouse □ Parent/Guardian

If not self: Name of insured _____

SS#: of insured ____-___-____ DOB of insured ___/___/_____

Who is financially responsible for patient balances after insurance?

□ Self □ Spouse □ Parent/Guardian □ Other _____

If not self: Name _____

Phone # ____-___-_____ DOB ___/___/_____ SS# ____-___-_____

Employer _____ Work #(____)____-_____

□ Address same as patient, or list if different

Address _____

Primary Care Doctor _____

Who referred you? □ Friend/family □ Phone book □ Other: _____

Consent for electronic communication from Griffith Eye Center:

□ I consent to receive text messages

Cell phone number (____)____-_____ Carrier: _____

□ I consent to receive email. Email address:_____

I authorize payment of medical insurance benefits to Griffith Eye Center for any services furnished to me by the doctors or staff of Griffith Eye Center. I authorize any holder of medical information about me to release any information needed to determine the benefits payable to Griffith Eye Center.

Signature _____ **Date** ____/____/_____