Patient Information

Thank you so much for choosing LaGrange Eyecare.
We are participating in the government's Meaningful Use Requirements Program, which is intended to improve care coordination and ensure security and privacy provisions for personal health information.
Please complete this form so we have accurate information about you.

Dr. Mr. Mrs. Miss Ms. Name:_____
LAST FIRST MI

Nick Name:_____

Date of Birth:_____/_____/_____ **Gender:** M F

Address _____**City**_____**State** _____

Zip Code _____ **Social Security** _____-_____-_____

Phone #'s: **(H)** _____-_____-_____ **(W)** _____-_____-_____ **(C)** _____-_____-_____

MARITAL STATUS:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family Doctor: _____ **Referring Doctor**:_____

Pharmacy Name/City_____ **Phone#** _____-_____-_____

Do you have internet access? YES NO **Email Address**:_____

Communication Preference: Home phone Cell Phone Mail

Emergency Contact: _____ _____ _____-_____-_____
Name relationship phone number

Race:

□ White □ Asian □ Black or African American

□ Native Hawaiian or Pacific Islander □ American Indian or Alaskan Native

Ethnicity:

□ NOT Hispanic or Latino □ Hispanic or Latino

Preferred Language: English Spanish OTHER: _____

Patient Information (cont'd)

Please hand your insurance cards to the receptionist with this form.

If you are not the subscriber for your insurance, please provide:

Subscriber Name_____ DOB _____/_____/_____

Subscriber SS# _____-_____-_____ Relationship to Patient _____

If this is a Worker's Compensation Exam, please provide **Employer information:**

Employer Name _____ Occupation _____

Address _____ City, State, Zip _____

Contact Phone (_____)_____ ext_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to Tennenbaum and Anstadt, Ltd.

I understand that I am financially responsible for charges not covered by assignment, co-insurance charge, deductibles, and non-covered services.

Patient's signature_____ Date_____

(Signature of insured or authorized agent, patient, or parent if minor)

How did you hear about us? (please "x" one)

_____ Phone Book _____ Website, www.anstadtproctoreyecare.com

_____ Other: _____

_____ Friend/Relative _____

Please provide your friend/relative's name so we can thank them for referring you to us