

# OCALA EYE, P.A.

## PATIENT INFORMATION RECORD



001

**CHART #** \_\_\_\_\_ **DR. #** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PATIENT'S NAME (PLEASE PRINT)					S.S.#					BIRTH DATE					AGE					SEX M   F														
MAILING ADDRESS										PERMANENT					TEMPORARY					CITY AND STATE					ZIP CODE					HOME PHONE#				
PATIENT'S OR PARENT'S EMPLOYER										OCCUPATION					HOW LONG					BUS. PHONE#														
EMPLOYER' STREET ADDRESS										CITY AND STATE										ZIP CODE														
MARITAL STATUS					SPOUSE OR PARENT'S NAME										S.S.#					BIRTHDATE														
S	M	W	D	SEP																														

**The Federal Government requires us to ask the following as part of the American Recovery and Reinvestment Act. Race: Please circle one**

American Indian or Alaskan Native Alone	Asian	Black or African American	Native Hawaiian or other Pacific Islander
White	Other	Unknown or Decline to provide	

**Ethnicity: Please circle one**

Hispanic or Latino	Non-Hispanic or Non-Latino	Unknown or Decline to provide
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**Language Preference: Please circle one**

English	Spanish	Other:
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NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU										PHONE #														
REFERRING PHYSICIAN										PHONE #					HOW DID YOU HEAR ABOUT US?									
PERSON RESPONSIBLE FOR PAYMENT					STREET ADDRESS, CITY, STATE										ZIP CODE					HOME PHONE #				

### INSURANCE INFORMATION

<b>PRIMARY INSURANCE</b>										<b>ID/POLICY #</b>					<b>GROUP #</b>				
SUBSCRIBER'S NAME										S.S. #					BIRTH DATE				
INSURANCE ADDRESS:																			
<b>SECONDARY / SUPPLEMENTAL INSURANCE</b>										<b>ID/POLICY #</b>					<b>GROUP #</b>				
SUBSCRIBER'S NAME										S.S. #					BIRTHDATE				

<b>MANAGED CARE PLAN (HMO)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO										AUTHORIZATION #					PRIMARY PHYSICIAN'S PHONE #				
<b>IF YES, DO YOU HAVE AUTHORIZATION?</b>																			
REQUIRE PRE-ADMISSION CERTIFICATION?										REQUIRE SECOND SURGICAL OPINION?					TEL. # TO CALL				
<input type="checkbox"/> YES <input type="checkbox"/> NO										<input type="checkbox"/> YES <input type="checkbox"/> NO									
INDUSTRIAL					WERE YOU INJURED ON THE JOB?					DATE OF INJURY					INDUSTRIAL CLAIM #				
<input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO														
ACCIDENT					WAS AN AUTOMOBILE INVOLVED?					DATE OF ACCIDENT					NAME OF ATTORNEY				
<input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO														

**I hereby authorize all licensed professionals employed by Ocala Eye to perform such professional diagnostic, laboratory, medical and surgical procedures as are necessary in their judgement, and to render such care and services as are customary and necessary.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_