ADULT PATIENT INFORMATION FORM

NAME: _____ M / F MARITAL STATUS: M S D W (please circle)

DATE OF BIRTH: _____

PRIMARY #: _____

CELL#: _____

WORK#: _____

SSN: _____

ADDRESS: _____
(home)

_____
CITY STATE ZIP

EMPLOYER: _____

SPOUSE INFORMATION (if applicable)

SPOUSE NAME: _____

DATE OF BIRTH: _____

CELL#: _____

EMPLOYER: _____

WORK #: _____

SSN: _____

ALTERNATE#: _____

PRIMARY INSURANCE

Insurance Name: _____

Policy #: _____

Group#: _____

Subscriber Name: _____

Subscriber SSN: _____

SECONDARY INSURANCE

_____

_____

_____

_____

_____

Referred by: _____

Eye Doctor: _____

PCP: _____

Specialist(s): _____

Emergency Contact Information (not living with the patient)

Name: _____

Phone#: _____

PRIMARY NUMBER YOU WOULD LIKE TO BE REACHED: _____

DO YOU WANT EMAIL REMINDERS OF YOUR APPOINTMENT? Y / N

EMAIL: _____

I hereby authorize the physician and employees to render routine medical care. The duration of this consent is indefinite and continues until revoked in writing.

I request that payment of authorized insurance company benefits be made on my behalf to Tracy C Crnic, MD, PA for any service furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information provided and have completed the above answers. I certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the given information.

Signature (Parent if minor) _____ Date _____

Information Reviewed and Confirmed as Correct by Patient/Parent

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

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Signature: _____ Date:_____