Lake Lazer Eye Center/U See Optical

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

PATIENT INFORMATION

Date ________________ Email address ____________________________@_________________

Last Name ____________________________ First Name ______________________ Initial _____

Phone#: __________________ Work#: ______________________ Cell#:____________________

Soc.Sec.# ______________________ Gender: M F Birthdate ________________ Age _______

Marital Status: S M W D Employed: Y N Student: Full-time Part-time

Home Address ____________________________ City _____________ State ____ Zip _______

Employer & Occupation _____________________________ Address __________________________

Whom we may thank for referring you? ____

Family Physician ____ Phone # ____________

In case of emergency, who should be notified? _________________________ Phone # ____________

CMS requires providers to report following information:

Preferred method of communication for reminders: Email/Phone/Mail Preferred Language ___________

Smoking Status (circle one): Everyday smoker / Occasional Smoker / Former Smoker / Never

RACE (circle one): American Indian or Alaska Native / Asian / Black or African America / White
Native Hawaiian or Pacific Islander / Other / Declined to answer

ETHNICITY (circle one): Hispanic or Latino / Not Hispanic or Latino / Declined to answer

Height: __________________ Weight: ________________ Blood Pressure: _________/___________

Current medications (please include regularly used over the counter):

____

____

Do you have any medication allergies? ____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize by insurance company to pay and hereby assign directly to LAKE LAZER EYE CENTER all the benefits, if any, otherwise payable to me for their services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, which received by and paid to LAKE LAZER EYE CENTER will be credited to my account in accordance with the above said assignment.

Authorized Signature of Subscriber ____________________________________ Date _____________