STORY EYE PATIENT INFORMATION

SOCIAL SECURITY NUMBER	TITLE	LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

BIRTHDAY (M/D/Y)	SEX (M, F)	RACE ☐ B-BLACK ☐ W-WHITE ☐ H-HISPANIC ☐ OT-OTHER	MARITAL STATUS ☐ S-SINGLE ☐ M-MARRIED ☐ D-DIVORCED ☐ W-WIDOWED ☐ X-SEPARATED	FAMILY PHYSICIAN

EMPLOYMENT ☐ R-RETIRED ☐ F-FULL ☐ P-PART ☐ N-NONE	STUDENT ☐ P-PART ☐ F-FULL ☐ N-NONE	REL. TO INSURED ☐ SE-SELF ☐ SP-SPOUSE ☐ CH-CHILD ☐ OT-OTHER	EMPLOYER/SCHOOL NAME

OCCUPATION	STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

SOCIAL SECURITY NUMBER	TITLE	LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

BIRTHDAY (M/D/Y)	SEX (M, F)	RACE ☐ B-BLACK ☐ W-WHITE ☐ H-HISPANIC ☐ OT-OTHER	MARITAL STATUS ☐ S-SINGLE ☐ M-MARRIED ☐ D-DIVORCED ☐ W-WIDOWED ☐ X-SEPARATED

EMPLOYMENT ☐ R-RETIRED ☐ F-FULL ☐ P-PART ☐ N-NONE	STUDENT ☐ P-PART ☐ F-FULL ☐ N-NONE	REL. TO INSURED ☐ SE-SELF ☐ SP-SPOUSE ☐ CH-CHILD ☐ OT-OTHER	EMPLOYER/SCHOOL NAME

OCCUPATION	STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	INSURED'S NAME	RELATIONSHIP	POLICY #

SECONDARY INSURANCE COMPANY NAME	INSURED'S NAME	RELATIONSHIP	POLICY #

EMERGENCY CONTACT

NAME	ADDRESS	PHONE

REFERRAL INFORMATION (please indicate how you heard of our office)

☐ Doctor *(name)* _____

☐ Friend/Relative *(name)* _____

☐ Newspaper *(which one)* _____

☐ Yellow Pages *(which one)* _____

☐ Other *(please specify)* _____

PLEASE READ AND SIGN BELOW

Assignment of Insurance Benefits and Consent to Release Information

I hereby request that payment of authorized health care benefits be made on my behalf to Story EyE for any services provided to me. I authorize release of any and all medical information needed about me to my health care plan or any agency assisting in payment for my care to determine benefits payable for related services. Furthermore, I authorize release of any information deemed necessary to my referring physician or any party consulted to participate in my care.

Consent to Medical Treatment

I do hereby voluntarily consent to such office and hospital care involving routine diagnostic procedures and medical treatment as considered necessary by my physician, Dr. John Story, his assistants or his designees. I acknowledge that no guarantees have been made to me concerning the result of any treatments or examinations to be rendered.

Payment Guarantees

The undersigned agrees to pay Story EyE all applicable deductibles, co-payments and charges for any services rendered that are not covered by insurance. I understand the filing of my insurance is a courtesy service and that I am ultimately responsible for payment of all services rendered.

_____ _____

Signature of Patient Date Insured/Responsible Party (if not patient)

Signature by Mark _____ Witness _____