Patient Information Form

Patient Name _____ Today's Date _____

Age _____ Birth date _____/_____/_____ Sex ☐ Male ☐ Female SS# _____

Address _____

City _____ State _____Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email_____

Patient Employer _____ Marital Status ☐ S ☐ M ☐ W ☐ D

Mother's Name if patient is a minor _____ Phone Number _____

Father's Name if patient is a minor _____ Phone Number _____

Insured Party and/or Guarantor Information ***(Person responsible for payment, if other than above or above is a minor)***

Name _____ Relationship to Patient _____

Date of Birth _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____Cell Phone _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Preferred Method of Contact ***(Select all applicable preferences)*** ☐ Phone ☐Mail ☐ Text ☐ Email

Race/Ethnicity ***(Select one)*** ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Not Hispanic/Latino

Preferred Language ***(Select One)*** ☐English ☐ Spanish ☐ Other

Insurance Information

*****PLEASE SHOW VISION AND MEDICAL INSURANCE CARDS TO THE FRONT DESK*****

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Blanco Kays Corgiat Eyecare, LLC to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Blanco Kays Corgiat Eyecare, LLC for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes Blanco Kays Corgiat Eyecare, LLC to act as my agent, as above.

_____ _____

Lifetime Patient/Guarantor Signature ***Date***