

**How did you hear about us?** \_\_\_ **Website** \_\_\_ **Facebook** \_\_\_ **Newspaper** \_\_\_ **Friend**  
\_\_\_ **Family Member** \_\_\_ **Doctor Referral** \_\_\_ **Other** \_\_\_\_\_

**Mr Mrs Miss Ms Dr Rev Sister:** \_\_\_\_\_  
(circle one) FIRST NAME MIDDLE INITIAL LAST NAME

**Mailing Address:** \_\_\_\_\_  
ZIP PLUS 4: \_\_\_\_\_ - \_\_\_\_\_

e-mail address: (required, if available) \_\_\_\_\_

**Sex:** M F **Marital Status:** Single Married Divorced Widowed Legally Separated

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Race:** (circle one) White American Indian or Alaskan Asian Black/African American Other \_\_\_\_\_

**Ethnicity:** (circle one) NOT Hispanic or Latino Hispanic or Latino Unknown

**Primary Language:** (circle one) English Spanish Other \_\_\_\_\_

**Home Phone Number:** ( ) \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_

**Cell Phone Number:** ( ) \_\_\_\_\_ **Carrier:** (Circle one) Verizon AT&T Sprint Other \_\_\_\_\_

**Reminder call preference:** (circle one) call home phone / call cell phone/ email / text message

**Your Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Your Occupation:** \_\_\_\_\_ **Retired:** Y N

**Spouse Name:** \_\_\_\_\_ **Spouse Employer:** \_\_\_\_\_

**Medical Doctor:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Emergency Contact Person(s):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Is there anyone you would like to give permission to inquire about your medical records at our office?

**Name(s):** \_\_\_\_\_

**Relationship(s):** \_\_\_\_\_

**Insurance Information: (Please present your cards to the receptionist to be copied)**

**Medicare:** \_\_\_\_\_ **Medicaid:** \_\_\_\_\_

**Medicare Supplement Insurance Name:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Health Insurance Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Policyholder Name:** \_\_\_\_\_ **Policyholder Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Vision Insurance Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Policyholder Name:** \_\_\_\_\_ **Policyholder Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Is your visit here the result of an accident? YES NO ( ) work related ( ) automobile ( ) other

**Insurance Company Name:** \_\_\_\_\_ **Job Site Supervisor Name:** \_\_\_\_\_

**Date of Injury** \_\_\_\_\_ **Brief Description of Accident** \_\_\_\_\_

On occasion, we make appointment reminder calls.

May we leave a message on your answering machine? (Circle one) YES NO Don't have answering machine

May we call you at work? (circle one) YES NO I am retired

**PLEASE READ AND SIGN THE PATIENT CONSENT FORM/ASSIGNMENT  
ON THE BACK OF THIS INFORMATION SHEET**

The HIPAA Privacy Rule gives individuals a fundamental right to be informed of the privacy practices of health plans and health care providers, as well as to be informed of their privacy rights with respect to their personal health information. This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

**Your Information. Your Rights. Our Responsibilities.**

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**Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

This represents a summary of your rights. The complete notice is available by requesting it from our receptionist.

**ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT**

It is the patient/guardian responsibility to know their insurance coverage. Patients should be aware of their benefits, including which providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co pays, and when they are eligible for services. If you are not familiar with your plan coverage, we recommend you contact your carrier directly prior to your services.

The patient/guardian authorizes payment of all private insurance, medical/surgical benefits, including major medical benefits to go to the Mabee Eye Clinic. A photocopy of this assignment is to be considered as valid as an original. The patient/guardian is financially responsible for all charges regardless of insurance.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian must sign if patient is under 18 years old

The Mabee Eye Clinic may share medical and/or billing information with the following persons involved with my care:

Name	Relationship	Date

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_