Patient Information

(Please print the following information)

Last Name ______________________ First Name ______________________ Middle Initial ______

SS Number ______________________ Date of Birth ______________ Sex: M F Marital Status: S M W D

Home Address ______________________ Apt/Unit # ______ Home Phone # ______________

City ______________________ State __________ Zip __________ Cell # ______________

Occupation ______________ Employer ______________________ Work # ______________

Name Of Spouse, Nearest Relative Or Responsible Party ______________________________

Emergency Contact Person ______________________ Relationship __________ Phone # ______________

Email Address ______________________

If You Have An "Out Of Town" Or Alternate Address And Phone, Please Complete:

Address ____

Phone# ______________________ List Dates Above Address is Valid: From __________ To __________

Do You Have Medicare? Y N Supplemental Insurance? Y N Name Of Supplemental Ins. ______________

Other Insurance? Y N Name of Other Insurance ______________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) POLICY:

I acknowledge that I have been given an opportunity to read a copy of the Pasadena Eye Center's policy relating to the Federal Government's HIPAA privacy regulations and how it relates to patient care. I also acknowledge that I have been given the opportunity to ask questions concerning this policy.

I understand that the staff will be using my first and last name to identify me throughout the office.

I give permission for Pasadena Eye Center &/or a third-party automated messaging system to contact me or leave a message concerning appointments, treatments, diagnoses, payments and other private health information on my home phone, mobile phone, email address or any other personal contact.

Yes __________ No __________

Please indicate below the names of individuals to whom we may release information contained in your medical chart.

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

By signing this form, I understand and acknowledge the above statements and give Pasadena Eye Center consent to release my personal medical information as indicated above.

______________________________ ______________________

Patient Signature Date