LaFollette eye clinic

the eyewear gallery

Welcome to our office! Please fill out the confidential information below:

Name:_____

Address: _____

City: _____**State:** _____ **Zip:** _____

RACE: Caucasian / African American / American Indian / Arab / Asian / Hawiian / Hispanic or Latino / Indian / Multiracial

ETHNICITY: □ Hispanic or Latino / Not Hispanic or Latino **PLEASE TELL US YOUR PREFERRED LANGUAGE:** _____

Birth Date: _____ / _____ / _____ **SSN #** (_____) (_____) (_____)

Home Phone # (_____) - _____ - _____

Cell Phone # (_____) - _____ - _____

Work Phone # (_____) - _____ - _____

Email Address:_____

We respect your privacy and we require contact information for office use only.

Name of Family Doctor:_____

Please circle all ways we may contact you about your care:

Mail Phone Answering Machine/Voicemail Email Text

Please list anyone with whom we may share your medical information:

_____

Responsible Party:_____**D.O.B.**_____/_____ /_____ **Phone**_____

Responsible Party Address:_____

Responsible Party SSN# (_____**)(**_____**)(**_____**) Relation to Patient:**_____

Responsible Party Employer Name:_____

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT:

- You assign your insurance benefits to us for the eye care we are providing you or your dependents.
- You authorize us to release information necessary to secure payment.
- You authorize us to use this signature on all insurance submissions.
- You have received the notice of privacy practices.
- You authorize us to contact you by mail, email, phone, or text message about your care

SIGNATURE _____ **DATE** _____

MEDICARE PATIENTS ONLY: These signatures are required for Medicare and Medigap patients only

I authorize LaFollette Eye Clinic (LEC) to release medical or other information about me to the SSA and HCFA or its intermediaries/carriers any information needed for any Medicare claim. I permit a copy of this signature to be used in place of the original and request payment of benefits to LEC or myself. Medicare regulations apply.

SIGNATURE AS IT APPEARS ON MEDICARE CARD: _____ Date_____

I request MEDIGAP benefits be paid on my behalf for services rendered. I authorize LEC to release to my MEDIGAP carrier any information needed for any MEDIGAP claim.

SIGNATURE AS IT APPEARS ON MEDIGAP CARD: _____ Date_____