FOUR SEASONS EYE CARE

Four Seasons Eye Care

Patient Information

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth:	Sex (please circle): Male Female

Address:	Apartment Number:

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Marital Status (please circle): Married Single	Primary Care Physician:	Employer Name:

Responsible Party If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:

Date of Birth:	Social Security Number:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

Additional Information Please fill out all sections below.

Email Address:	Preferred Language:

Race (please circle): -White -Black or African American -American Indian or Alaska Native -Asian -Hispanic -Native Hawaiian or Pacific Islander -Other -Decline to Specify	Ethnicity (please circle): -Hispanic or Latino -Not Hispanic or Latino -Decline to Specify

Preferred Pharmacy Name and City:	Preferred Pharmacy Address:

Primary Medical Insurance

Insurance Name:	Policy Number:

Policy Holder Name:	Date of Birth:

Secondary Medical Insurance

Insurance Name:	Policy Number:

Policy Holder Name:	Date of Birth:

CONSENT TO MEDICAL TREATMENT

As a patient of Don Sealock OD PA, I consent to medical care and treatment, as deemed necessary by their professional judgement.

ASSIGNMENT OF BENEFITS

I hereby authorize and request my insurance company to pay Don Sealock OD PA directly any insurance benefits for which I am eligible.

RELEASE OF INFORMATION

I hereby authorize Don Sealock OD PA to release information including the diagnosis, records of any treatment, or records of examination rendered, to third party payers and/or other health practitioners.

NOTICE OF PRIVACY PRACTICES

I have been informed of and/or offered a copy of Don Sealock OD PA's Notice of Privacy Practices.

CLINIC PAYMENT POLICIES

Co-payments are due at the time of service. I understand that my insurance company may pay less than the actual bill for services. I agree to accept financial responsibility, including all collection costs and reasonable attorney's fees. I understand there will be 1.5% interest per month on all balances over 60 days.

This will remain in effect until revoked by me in writing. A photocopy of this document is to be considered valid as an original.

Signature of Patient or Parent/Guardian of Minor _____ Date _____