medicalvision TECHNOLOGY

OPHTHALMOLOGY GROUP, INC.

PATIENT INFORMATION

DATE _____

NAME _____ E-MAIL _____
LAST FIRST M.I.

ADDRESS _____
STREET CITY STATE ZIP

HOME # _____ CELL # _____ WORK # _____

PREFERRED COMMUNICATION METHOD - HOME PHONE, MOBILE, EMAIL (circle one)

SOCIAL SECURITY # _____ AGE _____ BIRTHDATE _____ ☐MALE ☐FEMALE

RACE _____ ETHNICITY _____ PREFERRED LANGUAGE _____

NEED INTERPRETOR YES or NO (circle one)

OCCUPATION _____ EMPLOYER _____

PRIMARY INSURANCE _____ POLICY # _____

SECONDARY INSURANCE _____ POLICY # _____

VISION INSURANCE _____ POLICY # _____

MARITAL STATUS _____ SPOUSE'S NAME _____

SPOUSE'S BIRTHDATE _____ SPOUSE'S EMPLOYER _____

SPOUSE'S SOCIAL SECURITY # _____ SPOUSE'S WORK # _____

PARENT OR GUARDIAN NAME _____ S.S.# _____ BIRTHDATE _____

EMERGENCY CONTACT _____ PHONE # _____

FAMILY PHYSICIAN _____ PHONE # _____

IF YOUR INSURANCE COVERAGE IS THROUGH A SPOUSE OR OTHER FAMILY MEMBER YOU MUST FILL OUT THIS SECTION COMPLETELY

INSURED'S NAME _____ RELATIONSHIP _____

S.S.# _____ DOB _____ HM # _____ WK # _____

EMPLOYER NAME _____

INSURANCE POLICY _____ POLICY # _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

I _____ request any and all Medical Vision Technology (MVT) treatment and billing issues be discussed with .